Medical Economics

PUBLISHED EVERY OTHER MONDAY • ISSUE OF FEBRUARY 17, 1958

Why Blood Banking Is Still a Mess

Are Missile Stocks a Good Bet?

What Medicare Won't Pay You For

Higher Fees for the Nuisance Patient?

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1. Proctor, R. C.: Dis. Nerv. Sys. 18:223 1957. 2. Feuss, C. D., and Gragg, L., Jr.: Dis. Nerv. Sys. 18:29, 1957. 3. Coats, E. A., and Gray, R. W.: Dis. Nerv. Sys. 18:191, 1957. Registered Trademark: Quiactin

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Medical Economics

NEWS BRIEFS

AUTO ACCIDENTS hit a new high last year—so you'll soon be paying more for automobile liability insurance. Already announced: 14% to 33% price hikes in the Far Western states. Drivers elsewhere can expect about the same.

REGARDLESS OF ABILITY TO PAY: 388 medical societies now publicly guarantee to make M.D. services available to anyone who asks.

TAX-FREE ANNUITIES are being opened up to doctors who work full- or part-time for nonprofit institutions. The Mills bill (H.R. 8381), already passed by the House, permits large sums to be put into annuities for such employes without being taxed. Details in next issue.

INCOMES RISING FASTEST in the Southeast, where the per capita figure is now 14% higher than four years ago. In the Golden West, by contrast, per capita income is up only 10%.

NEWS BRIEFS

HOW DO YOU DIVIDE your charity dollar? Americans in general now allocate 51 cents for religion, 19 cents for welfare, 14 cents for health, 11 cents for education, 5 cents for other charitable causes.

ADMINISTRATION HAS GIVEN UP its three-year attempt to extend voluntary health insurance to 4,500,000 Federal civilian workers and their dependents, with the Government paying part of the cost. Health plan people and Government officials couldn't agree on details.

REFERRALS TO RESIDENTS? Hospital staff physicians should be required to refer "a proportionate number of patients" to senior surgical residents as a condition of staff membership. So says an American College of Surgeons committee headed by Dr. Carl A. Moyer. The idea is to make up for the sharp drop in charity cases available for teaching purposes.

HEALTH PLAN IN TROUBLE: New York City's Blue Cross plan is losing $1,500,000 a month. But the state insurance superintendent, under pressure from union and government subscribers, says rates can't be raised until all available reserves are gone. Local M.D.s' reaction: "Hell of a way to run a health plan!"

PEOPLE WILL PAY M.D.s $2,500,000,000 directly and $1,000,000,000 via medical insurance during 1958, the latest U.S. figures indicate.

LABOR HEALTH PLANS are being urged to take legal action against medical societies that are "frightening doctors not to join the medical staff of the plan." New pamphlet financed by the A.F.L.-C.I.O. tells union members: "Recent court decisions have created a body of precedents which will usually assure legal success, if the organization or the doctors (or both)...take their case to court..."

TAX REFUNDS DUE YOUR FAMILY? Any member who earned less than $600 last year "should file quickly to obtain refunds" of taxes withheld from his pay, the Revenue Service advises.

ATTORNEY MELVIN BELLI wins cases against M.D.s by dramatic demonstrations in court. Now he's won damages against a drug firm by using the same technique. Case concerned two children who contracted polio after being inoculated with Salk vaccine. According to press reports, "Belli wound up his arguments by parading the two polio-crippled children in the courtroom." The jury found no negligence--but awarded the plaintiffs $147,300 anyway.

XUM

NEWS BRIEFS

HOW LONG TO KEEP X-RAYS? At least five years, the American College of Radiology recommends--ten years in the case of "apparently negative chest films of adults." And before discarding any film, consider giving it to the patient.

JENKINS-KEOGH HEARINGS have brought out that tax deferments on retirement savings would cost the Government much less in lost revenues than originally estimated. This testimony led one A.M.A. observer to say: "Passage looks more possible this year than ever before."

MEDICAL CAREERS REGAINING APPEAL: The number of medical school applicants is rising again, after a five-year fall-off. Some 16,800 individuals sought admission to last fall's freshman classes, the Association of American Medical Colleges estimates. That's well above the 1954 low point (14,538 applicants) but still far from the 1949 figure (24,434 applicants).

"LIKE IT OR NOT, organized labor will be exerting more influence in the health and welfare fields than ever before," says the A.M.A. "Rather than wait till a union health plan is announced...medical societies should volunteer their guidance and counsel now to local A.F.L.-C.I.O. Community Relations Committees..."

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XUM

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Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, FEB. 17, 1958

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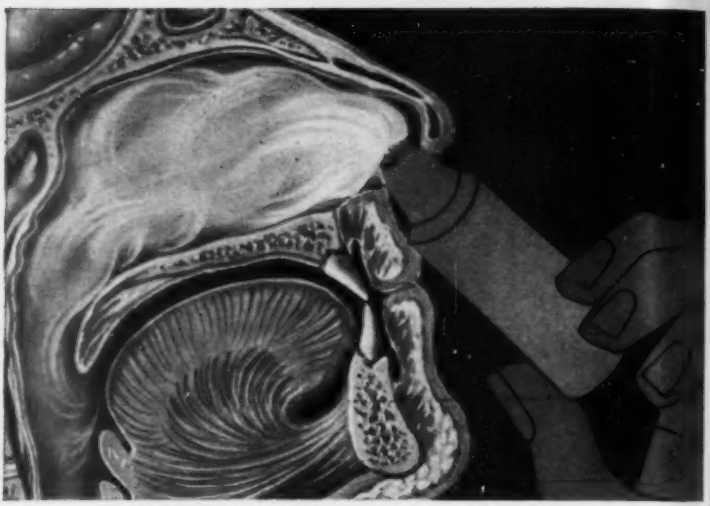

how your patients can relieve nasal congestion in seconds

Those "inaccessible" areas—The vasoconstrictive vapor of 'Benzedrex' Inhaler diffuses evenly *throughout* the nasal cavity, opening ostia and ducts which are frequently inaccessible to other intranasal preparations. Drainage is established; congestion relieved; headache, pressure pain and "stuffiness" alleviated.

A major research achievement—The active ingredient in 'Benzedrex' Inhaler is propylhexedrine, a compound developed by S.K.F. specifically to provide rapid and prolonged decongestion. (Each Inhaler is packed with propylhexedrine, S.K.F., 250 mg.; and aromatics.)

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links
freedom from
anginal attacks

with a shelter of
tranquility

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"Cardiac patients who show significant manifestations of anxiety should receive ataractic treatment as part of the therapeutic approach to the cardiac problem."[1]

1. Waldman, S., and Pelner, L.: Am. Pract. & Digest Treat. 8:1075 (July) 1957.

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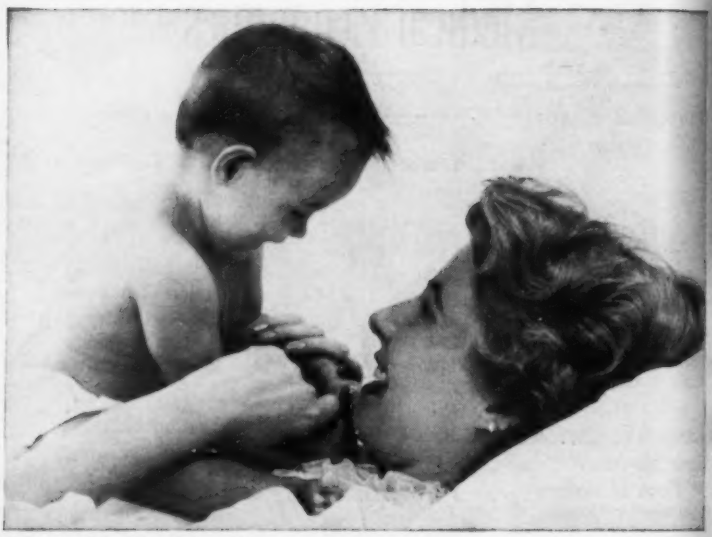

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Noxzema is pleasant to use—greaseless, non-sticky, won't stain or mess up clothing. You can recommend Noxzema with confidence. Its effectiveness has been not only clinically tested, but proved in actual home use for over 25 years.

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Regular Noxzema Skin Cream, a modernization of Carron Oil, fortified by adding Camphor, Menthol, Oil of Cloves and less than ½% of Phenol, is a greaseless, solidified emulsion. Its reaction is almost neutral—the pH value being 7.4.


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the cough
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Letters

The Green Poultice

SIRS: The public doesn't realize it, but one big reason for the high cost of medical care is the medical profession's fear of unjustified malpractice suits. Doctors and hospitals alike are forced to take account of the occasional patient who develops strange symptoms that respond to only one treatment: application of "the green poultice." (In case you haven't heard, the green poultice is a substantial monetary judgment awarded by a jury of sympathetic laymen.)

So we must all take expensive measures to guard ourselves against such suits. That's why hospital labs, X-ray rooms, and records rooms are more heavily staffed than they need be. And *that* in turn is why hospital patients must be billed at high rates.

As for us doctors—well, take this example from my own practice:

As an ENT man, I do many operations to correct obstructive blockades in the middle partition of the nose. The bent cartilage that often causes such blockades is easily visible on examination. X-rays are of little or no help to me. But I refuse to operate on a nose without first taking X-rays of it. Why? Because I don't want to be adjudged "negligent."

Result: A needless $15 or $25 is added to the patient's bill.

Joseph J. Littell, M.D.
Santa Rosa, Calif.

SIRS: It's clear that many malpractice actions brought against doctors are mere nuisance suits, without foundation. The proof: Any number of them are either decided against the plaintiff or dropped.

Regardless of the outcome, though, the physician who's sued suffers mental torment as well as loss of time and prestige. Even after he's cleared, it's on record that his professional skill and judgment have been questioned. So wouldn't

he be justified in filing a *countersuit?*

I believe the claimant and his lawyer in a groundless malpractice suit should be held responsible. If the defendant doctor can show defamation of character and unwarranted loss of patients, income, time, and prestige as a result of the suit, he deserves compensation.

H. Clinton Davis, M.D.
Miami, Fla.

Blue Shield Flaws

SIRS: Your recent articles on Blue Shield have failed to discuss two reasons why many physicians have lost sympathy with their own plan:

The first reason is the extremely irritating paperwork. Blue Shield forms have been returned to me because I'd omitted such minor details as the patient's age or address, the hospital's address, or whether the patient was a subscriber or spouse. In each case, Blue Cross had long since paid; so the information was obviously available to Blue Shield too.

Secondly, there's the manifest unfairness of paying the same fee to an internist, a G.P., and a professor of medicine. Society has come to feel that the various categories of doctors should be rewarded differently. And society's attitude won't yield graciously to administrative fiat.

I for one can't help wondering whether I might not do better to resign from Blue Shield entirely. If this feeling spreads, Blue Shield membership may come to be a badge of philanthropy or a mark of economic desperation.

M.D., Pennsylvania

Doctors' Doctors

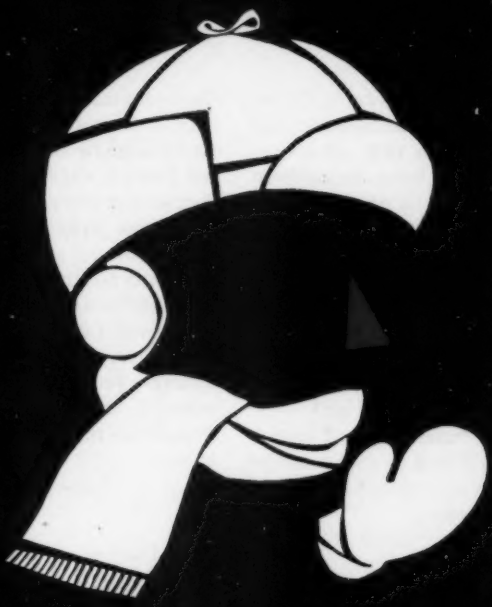
SIRS: One of your correspondents suggests that no doctor willingly puts his own family in the hands of a general practitioner. Let me recount my own experiences—and *then* let him judge:

A few years ago, I had gallstone colic. I showed the X-rays to our hospital's leading surgeon—one of the louder exponents of the G.P.s-are-incompetent theory. He agreed that my gallbladder should come out.

The day before the operation, an interne did my history and physical. The surgeon himself didn't even punch me in the belly. And when, on the third evening after the operation, I was most uncomfortable, the nurses had orders not to disturb the surgeon—this at 9 P.M. So it was the night supervisor who decided to give me an injection of morphine.

Compare that sort of care with the following:

When our infant child was seriously ill with viral gastroenteritis, a G.P.-colleague gave him constant and ungrudging attention during eleven harrowing days. The same man attended my wife during a



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Note: As with certain other widely used nasal decongestants, overdosage may cause drowsiness or deep sleep in infants and young children; KEEP OUT OF HANDS OF CHILDREN OF ALL AGES. Tyzine Nasal Spray and Tyzine Nasal Solution, 0.1%, are not recommended for use in children under six. When using Tyzine Nasal Spray in the plastic bottle, it should be administered only in an upright position.

Roberts, J. G.: M. Times 84:1282; 1956.

Pfizer *Brooklyn 6, New York*

Division, Chas. Pfizer & Co., Inc.

subsequent pregnancy. In the eighth month, she developed a mild toxemia, and the G.P. did a Caesarean section. When the newborn baby developed an inguinal hernia, the same G.P. repaired it.

It doesn't surprise me that my family are now in good shape. They've had the conscientious care of a first-rate general practitioner. Do you think I'd risk their lives in the hands of such men as the surgeon who operated on me?

I'm not bitter about *all* specialists. But I'll send my own family to specialists only when I deem it absolutely necessary.

M.D., California

SIRS: . . . My father is now under treatment by a G.P. for fractured vertebrae. I recently collaborated with another G.P. on an appendectomy on his own son. And I know several G.P.s who have done their own wives' deliveries.

We like to have you specialists around for consultation and help —whether the patient is a member of the family or not. But don't flatter yourselves too much. Sometimes you're called only as a convenience.

Edmund V. Olson, M.D.
Olympia, Wash.

Insurance Forms

SIRS: Too often, the form assigning a patient's health insurance benefits to his doctor is lost or misfiled by the insurance company. As a result, the patient gets paid, but the doctor may not. I'd like to suggest a simple way for your readers to make sure they get paid directly:

Why not attach the assignment form to your bill and rubber-stamp across the face of the bill BENEFITS ASSIGNED TO DOCTOR? Then, even if the assignment form accidentally becomes detached, the insurance people will know that it exists. If they don't find it, the chances are that they'll notify you immediately.

Ralph R. Benson, LL.B.
Los Angeles, Calif.

SIRS: I wish to warn my colleagues against giving medical information on life insurance application forms without first checking with the patient.

Some such forms bear the statement: "You are entirely justified in furnishing this information because every applicant has signed a release." Yet in one case I handled, it turned out that the patient knew nothing about the application for insurance. Her husband had submitted it.

Luckily, my Girl Friday kept me from filling out the form and sending it in. I *could* have been in the soup if the patient hadn't wanted the information disclosed.

John F. Spahr Jr., M.D.
Indianapolis, Ind.

END

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safer than aspirin, easier to use

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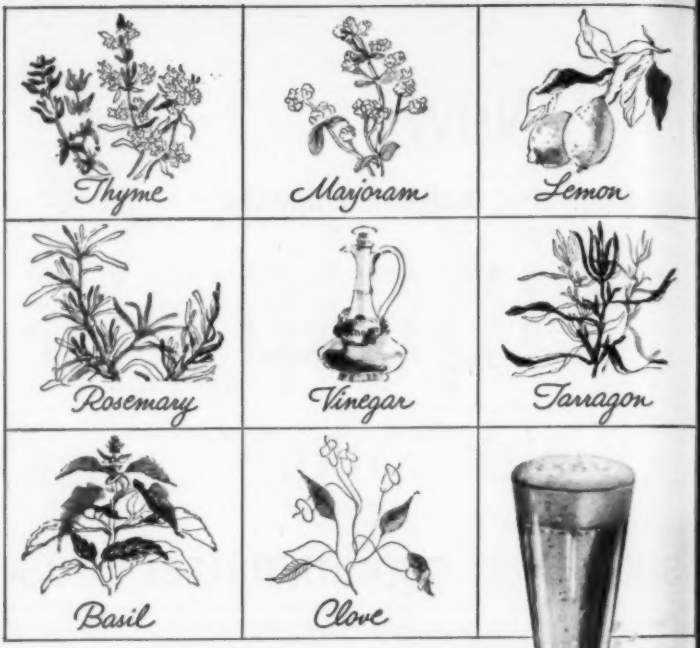

A few suggestions on how to give your patient a diet he can "stick-to"—

The Low Sodium Diet

Here are some things your patient can do to season his Low Sodium Diet. Spices and herbs, lemon and lime, variously flavored vinegars and pepper are all he needs.

Thyme, marjoram and pepper add new zest to hamburger. Chicken's delicious with lemon, rosemary and sweet butter to baste.

He can try savory on limas, tarragon with carrots, basil with tomatoes. Onions boiled with whole clove and thyme delight the taste of an epicure! With these flavor tricks to add zest to his meals—and a glass of beer* now and then, at your discretion, your patient has a diet he can "stick-to."

*Sodium: 7mg./100 gm., 17 mg./8 oz. glass (Average of American Beers)

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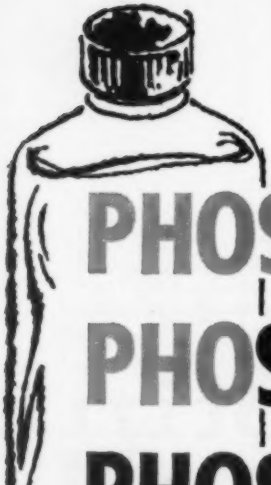

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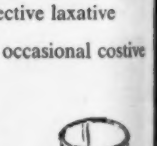

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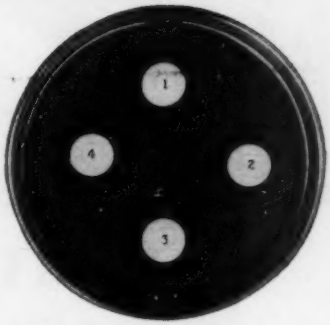

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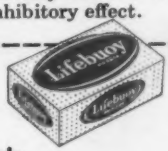

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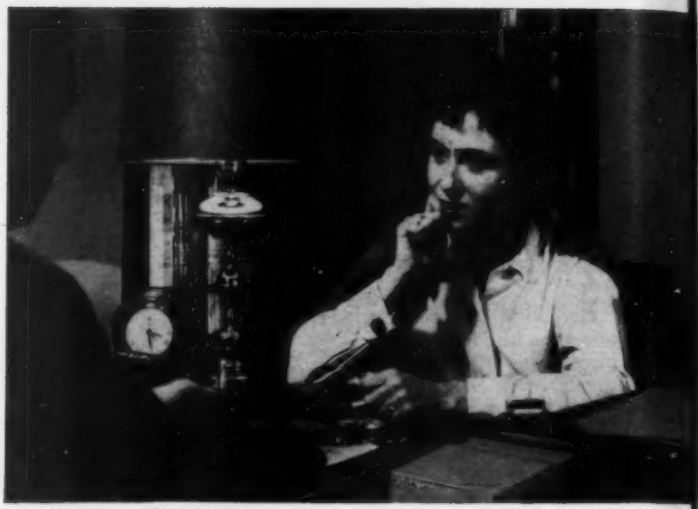

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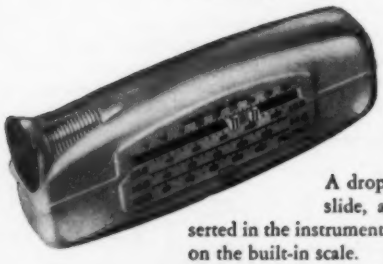

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Adult dosage for ACHROCIDIN Tablets and new caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

Available on prescription only.

TABLETS *(sugar coated) Each Tablet contains:*

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
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Salicylamide	150 mg.
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Bottles of 24 and 100.

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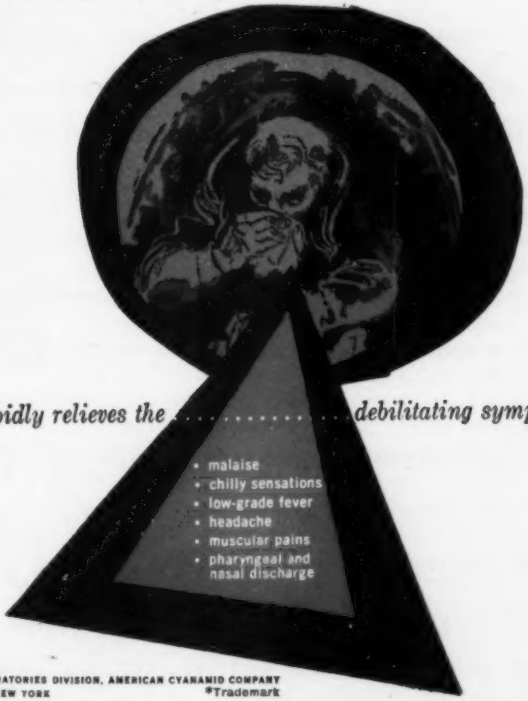

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News

State Medicine's Chances? None, He Says Now

Has the threat of Federal health insurance evaporated? One former advocate of such insurance thinks it has, at least for this generation. Government health insurance today is "a dead issue," says Harry Becker, who, as the C.I.O.'s expert on health, once supported the Murray-Dingell bill. In 1953 Becker began saying: "Voluntary plans can do the job." Today he is assistant vice president of the Blue Cross Association. As such, he now says:

Becker

"The voluntary plans . . . plunged forward to demonstrate their potential while the case for Government-administered health insurance was still being argued." Today they are rapidly approaching a level of benefits "far in excess of any floor of protection that would be provided under a universal national government program." And as a result of collective bargaining, "voluntary prepayment has become such an integral part of employer-employe relations that a reversal of current . . . trends is hardly within the realm of practical possibility."

Thus, as Becker sees it, "the case for a Government-operated health insurance system has probably . . . been defeated—at least for our generation."

What about after that? Well, pressure for Government health insurance *could* be renewed if the voluntary plans failed to extend their benefits evenly through the whole community, Becker believes. For example:

"The present situation of one standard of protection for . . . members of an employe group and . . . another standard for other population groups cannot prevail much longer. Voluntary prepay-

ment must solve this problem or it will fail in its initial social and economic purpose to provide adequate protection for all in the community and thus [to] make unnecessary a [Federal] health insurance system."

Profitable Hobby: U.N. Stamps

Thousands of physicians collect stamps. And hundreds of them have discovered a new way to make the hobby profitable as well as pleasurable: Buy United Nations postage stamps.

First issued in 1951, the U.N. stamps suddenly became popular with collectors in 1955. Since then they have soared in value—particularly the rarer ones. According to the United Nations Philatelic Information Committee, anyone who bought a sheet of each U.N. stamp as it was issued would now have a collection worth more than $1,000. Original cost: about $100.

And philatelists say the rarer stamps are still a good investment. Reason: The market for them is showing signs of rising after a recent downswing.

Poll Shows Most M.D.s Do Industrial Work

What proportion of doctors do at least some industrial practice? In one state, about three out of four, according to Dr. Jean Spencer Felton of the University of Oklahoma School of Medicine.

Dr. Felton recently sent questionnaires to every physician in Oklahoma. He reports that 16 per cent of his respondents get at least one-fifth of their income from industrial work. Another 59 per cent get up to one-tenth of their earnings from this source. The bulk of them see industrial patients only in their own private offices.

But while most of the Oklahoma men do some industrial work, less than a third of them are interested in doing more, Dr. Felton reveals. He quotes one doctor as explaining: "Industrial work involves too many reports unless one sets up an office routine for volume."

Major Medical Insurance Hurt by High Fees

Insurance carriers have long complained that some doctors scale up their fees when they find the patient has ample insurance. Now, with the rapid growth of major medical insurance, they feel it's getting worse.

This view has been expressed by many insurance company medical directors. Recently one of them —Dr. William J. McNamara of the Equitable Life Insurance Society—made public these examples of fees his policyholders had been asked to pay:

even if your patient is a

gandy dancer†

†railroad man's term for track section hand

...he'll be back on the track with

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Low back syndromes ... sprains ... strains rheumatic pains ...

FLEXILON gets them back on the job *fast.*

Each tablet contains:

FLEXIN® Zoxazolamine‡ . . . . . 125 mg.
The most effective oral skeletal muscle relaxant

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The preferred analgesic for painful musculoskeletal disorders

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when children catch cold

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turn
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monitors the cough *and* the cold in children and adults

XUM

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Salicylamide	0.19 Gm.
Phenacetin	0.13 Gm.
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¶ Fee for dilation, curettage, and cauterization of the cervix: $1,200. Patient's annual income: $6,000.

¶ Fee for excision of semilunar cartilage of the knee: $1,000. Patient's annual income: $4,000.

¶ Fee for a gastrectomy: $1,500. Patient's annual income: $3,000.

¶ Fee for a lobectomy: $2,500. Patient's annual income: $2,500.

What are the companies doing about this sort of price-hiking? If they follow Dr. McNamara's example, they're making a direct appeal to the doctor in each questionable case. Appeal to a local grievance committee is only a second-best solution, Dr. McNamara thinks: "Although these committees are sympathetic to a grievance from an individual, [they] frequently are less sympathetic toward insurance companies with their great assets."

'Insurance Reports Can Be Used Against You'

In your medical reports to insurance companies, do you allow any assumptions to creep in among the facts? Do you phrase your findings in such a way as to increase the patient's chances for collecting benefits?

"Don't!" the San Francisco Medical Society has warned its members. "Such reports can backfire on you."

To prove its point, the society tells how such a report lost a malpractice case for one of its members. Here are the highlights:

A San Francisco orthopedist had a patient who'd been getting infra-red treatments. The patient came in the day after one such treatment and showed the doctor a large rectangular area of first- and second-degree burns. He said they'd been caused by the doctor's heat lamp.

The doctor hospitalized him, then sent the patient's insurance company a report of the injury. The wording of the report gave the patient the benefit of all doubt as to how the injury had happened. The doctor apparently worded it that way so as to be sure the man got compensation.

The man did. But later he sued the orthopedist for malpractice. And when the doctor and his local malpractice defense committee reviewed the case together, they found facts to indicate the man had inflicted the burn on himself. (Key fact: The doctor's lamp couldn't have made a rectangular burn.)

These facts were presented at the trial, and the jury found for the orthopedist. But then the judge intervened. He declared the verdict "clearly wrong." Why? Because the doctor's original report to the insurance company had said:

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"The patient allowed his left leg to stay under the infra-red lamp too long and as a result he developed first- and second-degree burns . . . This was not entirely the fault of the patient . . ."

On the strength of this damaging assumption, a new trial was ordered. Fearing the outcome, the doctor settled for $5,000. Thus his own written report cost him his case.

One Area's M.D.s Reject New Welfare Program

The latest plan for financing the medical care of people on Public Assistance has hit a snag in one state. The plan is for Federal and state governments to put up equal funds to meet the medical expenses of such people. Doctors elsewhere have gone along with the scheme. But the doctors of Santa Barbara, Calif., have indignantly rejected the project as a form of "socialized medicine."*

Instead of accepting Federal-state funds for indigent care, the Santa Barbara doctors are following this policy:

"Where any person or a responsible member of his family is financially unable to pay for med-

*For some other objections to the new plan, see "Revised Welfare Law May Hurt Some Doctors," MEDICAL ECONOMICS, Jan. 6, 1958.

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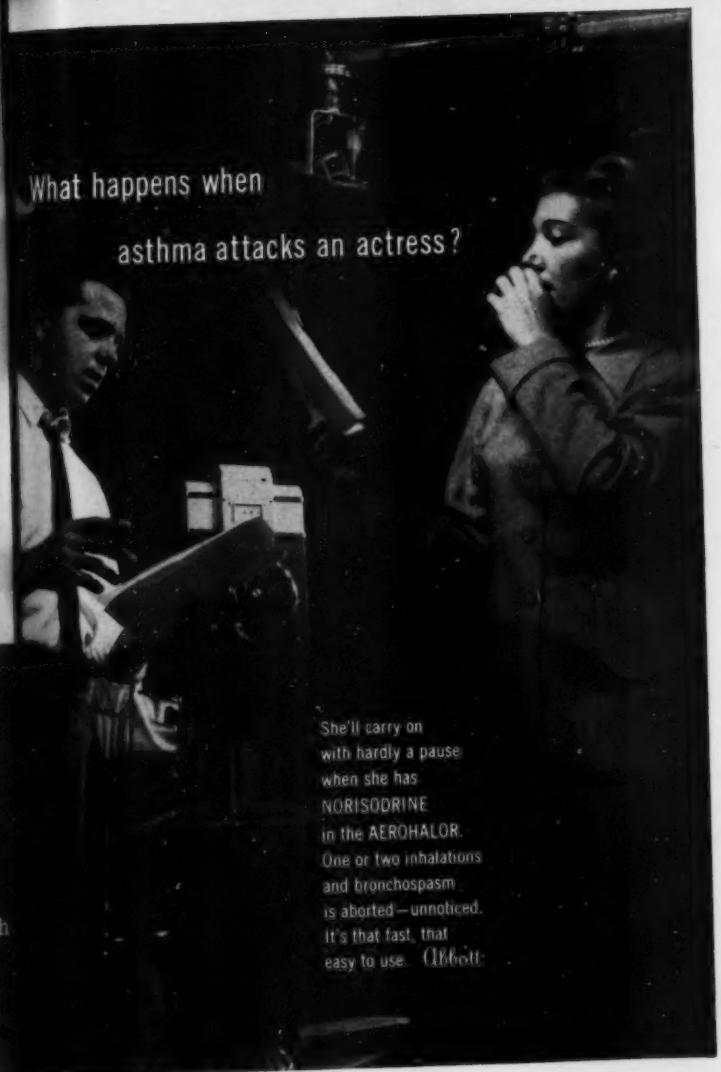

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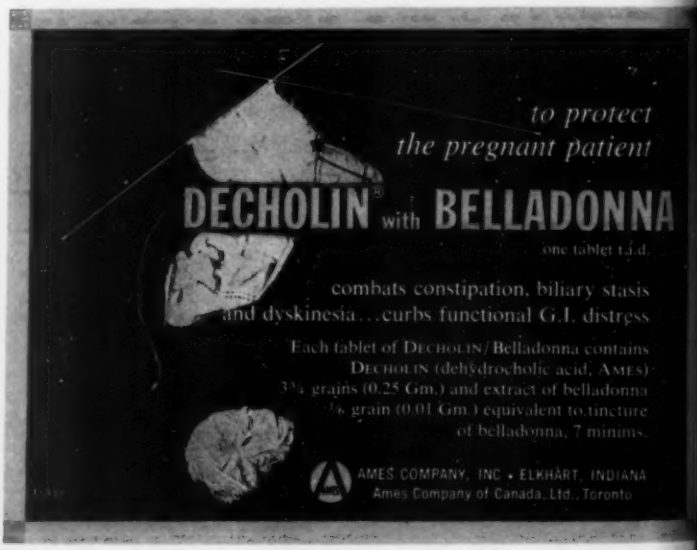
ical services . . . we will continue to provide this service free of charge or make proper arrangements for the patient to receive care at our county hospital or [at our] county clinics."

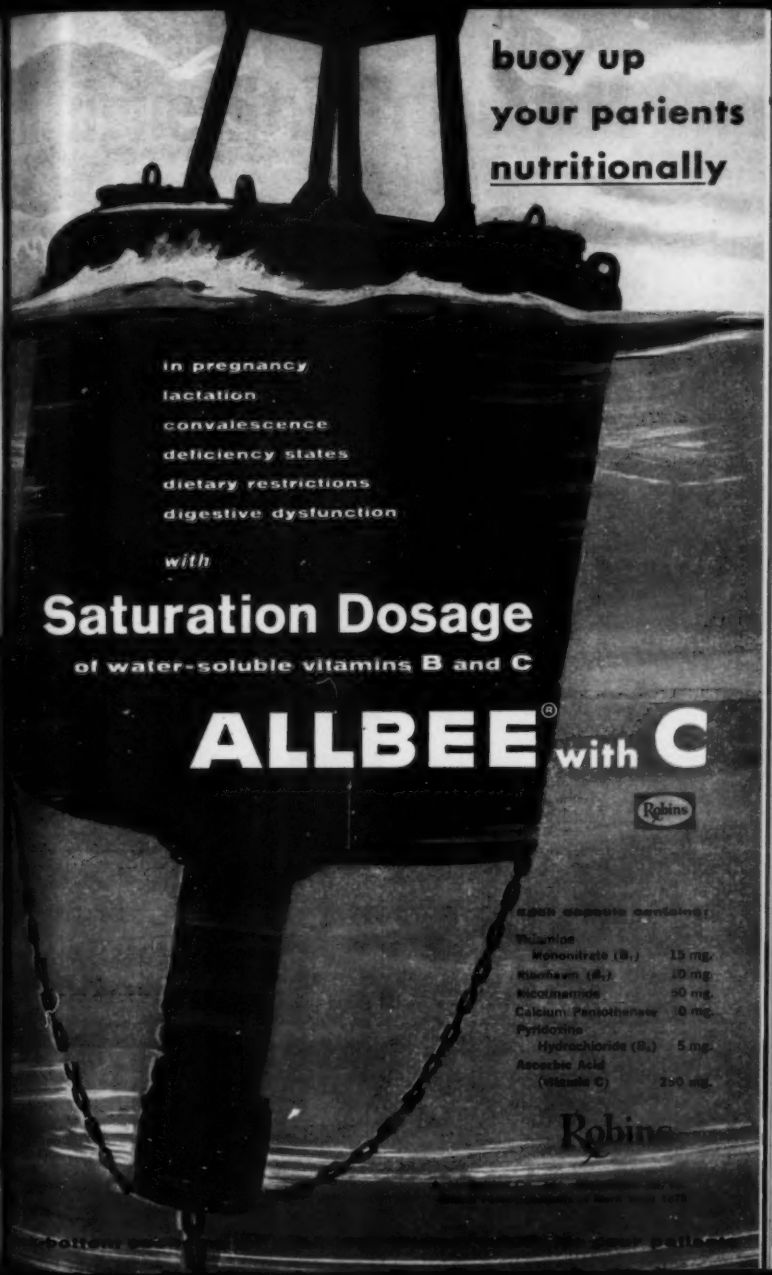
The Santa Barbara doctors give two reasons for their stand. First, they predict the Federal-state welfare program will lead to "staggering taxes." Secondly, they foresee a "piecemeal addition" of population groups until the program covers many more people than just Public Assistance cases, for whom it was originally planned:

"In a short time, political pressure groups will undoubtedly introduce legislation to include medical care for all recipients of Social Security. Other groups to follow may include veterans and their families, Federal employes, and labor groups."

That's why Santa Barbarans believe it's time to draw the line. Says their medical society president, Dr. Douglas F. McDowell: "If other county medical societies throughout the United States will take similar action . . . we believe socialized medicine can be defeated in every state and on a national level."

Dr. McDowell's challenge has already produced action elsewhere in California. The Orange County Medical Association has voted to boycott the new Federal-state pro-

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INDICATIONS: Hypertension of all degrees of severity.

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What do you do with your car when you drive up to the hospital in a rush? Today you may waste time looking for a parking place. But not tomorrow—not if your hospital follows the lead of the Flower Hospital in Toledo, Ohio.

What's this institution's solution to the problem?

Flower believes that it's "the first drive-in hospital in the U. S." It has rebuilt its entrance so that cars can come within a few feet of the emergency ward. Attendants wait round the clock to park your car for you. You can be at work seconds after you're in sight of the building.

Fluoridation Foe Loses Lawsuit

The opponents of fluoridation have received another setback. Dr. Frederick B. Exner of Seattle, Wash., has lost an appeal to his state's Supreme Court—and this ends his ill-fated two-and-a-half-year legal fight to collect a $1,000 award.

The award was offered by the Chehalis (Wash.) Fluoridation League. It was payable to anyone who could prove that fluorides, in the proportion of one part per

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VAGINITIS:

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million, ever had an "ill effect" on anybody anywhere. Dr. Exner made a bid for the award. When the Fluoridation League wouldn't pay him, he took his case to court. The trial attracted national publicity because both sides brought in medical experts from other parts of the country.

The trial judge decided against Dr. Exner and the anti-fluoridationists. He said they had failed to prove their claim that fluorides could disfigure teeth. Besides, he ruled, no one had testified that disfigured teeth were necessarily an "ill effect." The Washington Supreme Court has now upheld this decision.

But Dr. Exner's legal defeat doesn't erase his earlier victory at the polls. The reward was originally offered in the course of a fluoridation referendum in Chehalis. Thanks largely to Dr. Exner's efforts, Chehalis voters decided *not* to add fluorides to their drinking water.

Hospitals Said to Lack Examining Facilities

Many doctors work hard at educating female patients to come in for routine pelvic examinations. "Why are we not applying this important doctrine to patients already within our grasp?" asks Dr. John Y. Howson of Philadelphia.

He's referring to hospitalized patients. And he goes ahead and answers his own question this way:

When the bronchial tree has too much "bark"

***make cough* MORE PRODUCTIVE, LESS DESTRUCTIVE**

"Significantly superior"[2] cough therapy for "markedly" reducing the severity and frequency of coughing,[1] for increasing respiratory tract fluid,[1] for making sputum easier to raise,[3] and for relieving respiratory discomfort.[4]

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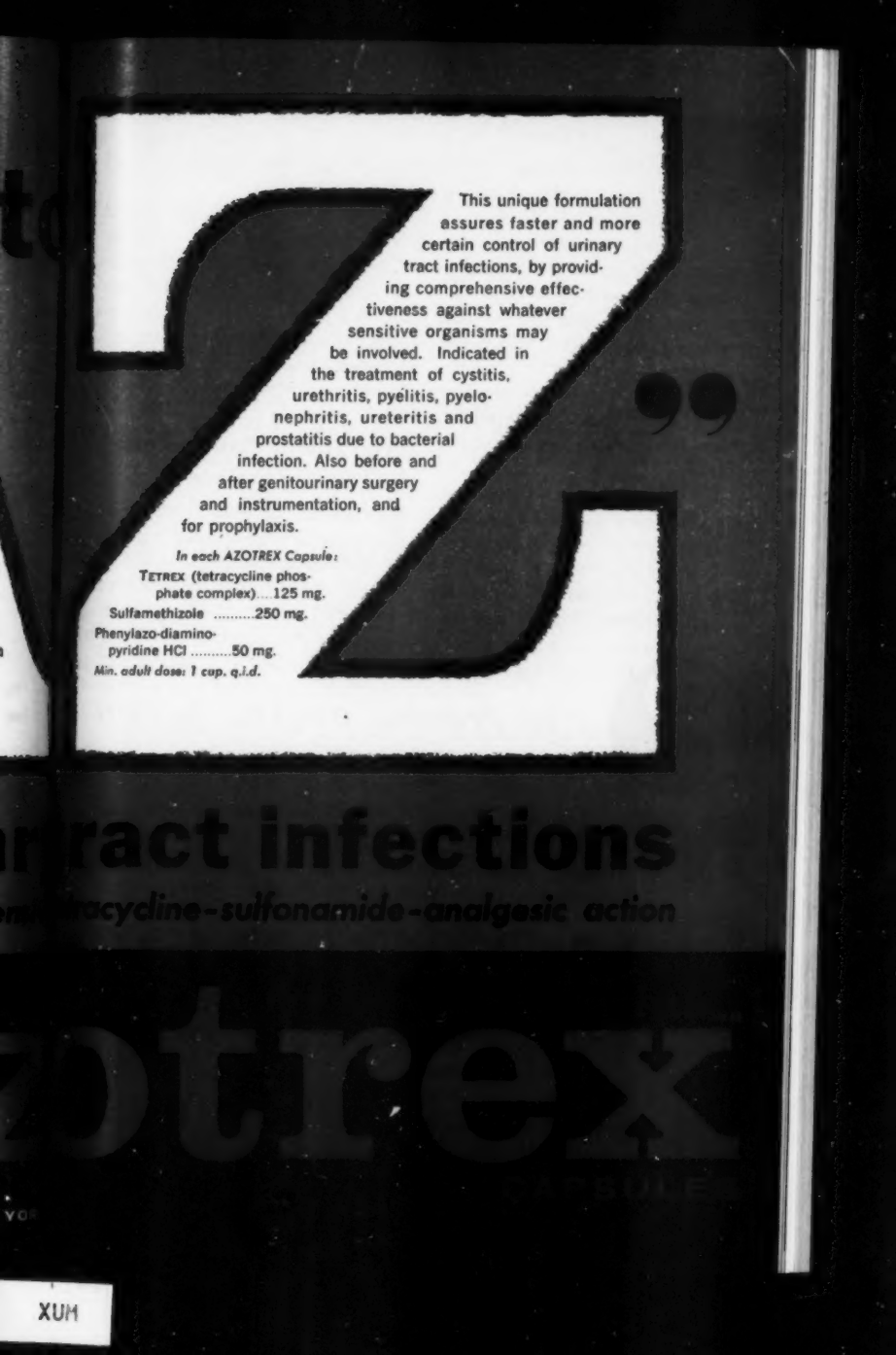
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Min. adult dose: 1 cap. q.i.d.
ract infections
racycline-sulfonamide-analgesic action
zotrex

"Most hospitals do not provide facilities for doing pelvic examinations on in-patients . . ."

Dr. Howson has been studying delays in detecting pelvic malignancies. All too frequently, he says, "hospital charts still exhibit that cryptic phrase 'rectal and pelvic examination deferred.'" Why? Because there are no "examining rooms on or near the in-patient floors for carrying out this examination."

Dr. Howson suggests two ways his colleagues can help get these hospital facilities:

Doctors on hospital staffs, he says, "should press the issue with hospital administrations and demand space and equipment [as] necessary."

Beyond that, staff doctors should "consider bringing this . . . to the attention" of the Joint Commission on Accreditation. At present, Dr. Howson points out, the Joint Commission doesn't require such examining rooms—and maybe it should require them.

Blue Shield Plan Lowers Its Income Ceiling

Nationwide, the Blue Shield trend is toward higher income ceilings for full-service benefits. Is it possible to check this trend—or even reverse it?

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1 tablet all day
1 tablet all night

to prevent angina pectoris

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Triethanolamine trinitrate biphosphate, LEEMING, 10 mg.

Sustained

special advantages:

Simplified dose (b.i.d.)
No undesirable side reactions.
Greater economy.

A LEEMING 1ST

Usual dose: 1 tablet on arising, 1 before evening meal. Bottles of 50 tablets.
THOS. LEEMING & CO., INC., New York 17, N. Y. *Patent applied for.

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preparation to fit each patient's need

For simple iron-deficiency anemia—

MOL-IRON TABLETS/LIQUID

bottles of 100 *bottles of 12 fl. oz.*

Each tablet or teaspoonful of liquid contains ferrous sulfate, 195 mg. (3 gr.), and molybdenum oxide, 3 mg.

DOSAGE: Adults—2 tablets or 2 teaspoonfuls of liquid t.i.d.; children—1 tablet t.i.d. or ½ to 1 teaspoonful t.i.d.

For protection against iron deficiency during infancy—

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DOSAGE: Children up to 6 years—0.3 cc.; over 6 years—0.6 cc. daily.

For iron-deficiency anemias complicated by impaired absorption of iron—

MOL-IRON c̄ VIT. C TABLETS

bottles of 100

Each tablet equals one Mol-Iron tablet plus 75 mg. ascorbic acid.

DOSAGE: As required—1 or 2 tablets t.i.d.

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choose the right iron

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SULFAMETHOXYPYRIDAZINE LEDERLE

New authoritative studies show that KYNEX dosage can be reduced even further than that recommended earlier.[1] Now, clinical evidence has established that a single (0.5 Gm.) tablet maintains therapeutic blood levels extending beyond 24 hours. Still more proof that KYNEX stands alone in sulfa performance—

- Lowest Oral Dose in Sulfa History—0.5 Gm. (1 tablet) daily in the usual patient for maintenance of therapeutic blood levels
- Higher Solubility—effective blood concentrations within an hour or two
- Effective Antibacterial Range—exceptional effectiveness in urinary tract infections
- Convenience—the low dose of 0.5 Gm. (1 tablet) per day offers optimum convenience and acceptance to patients

NEW DOSAGE—The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

Tablets:
Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup:
Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

1 Nichols, R. L. and Finland, M.: J. Clin. Med. 49:410, 1957.

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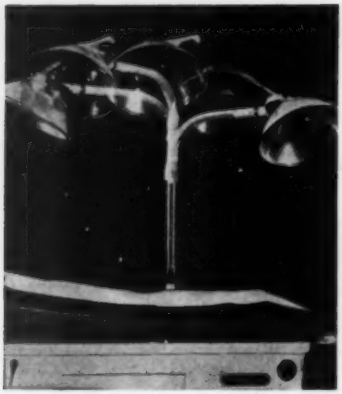

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Castle LIGHTS AND STERILIZERS

Hawaii may produce the answer. Doctors there recently found it necessary to *lower* their plan's income ceilings.

Until 1955, Hawaii's regular Blue Shield plan was much like the standard stateside version. It had income ceilings of $3,600 for single subscribers, $4,800 for families. Those people who had higher incomes got indemnity coverage only.

Then a second plan was added on an experimental basis. Its income ceilings: $7,500 for individuals, $10,000 for families. Membership in the experimental plan quickly shot up to 40,000. At the same time, enrollment in the regular Blue Shield plan increased too.

But when Hawaii's physicians took stock, they realized they were treating so many patients at reduced Blue Shield rates that their earnings were falling off. "The doctor is penalized," said a Honolulu County Medical Society committee report, "when the [Blue Shield] income level includes 95 to 99 per cent of the people in the community [and when] the fee schedule is lower than the usual fees the doctor charges."

Hawaiian doctors didn't feel they could drop their high-ceiling plan; it was too popular. So they combined it with the old plan and set new income ceilings at $4,800 for individuals, $7,800 for families. This is proving acceptable to subscribers because, for three-

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prednisolone and hydroxyzine

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scored green tablets,
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bottles of 30 and 100

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Vitamin A	1.5 mg. (5000 units)
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Bevidoral® *(Vitamin B_{12} with Intrinsic Factor Concentrate, Abbott)*	½ U.S.P. Unit (oral)
Ferrous Sulfate, U.S.P.	75 mg.
Folic Acid	0.25 mg.

CAPILLARY STABILITY

Ascorbic Acid	50 mg.
Quertine® *(Quercetin, Abbott)*	12.5 mg.

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Betaine Hydrochloride	50 mg.
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ANTI-DEPRESSANT

Desoxyn® Hydrochloride *(Methamphetamine Hydrochloride, Abbott)*	1 mg.

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Sulestrex® *(Piperazine Estrone Sulfate, Abbott)*	0.3 mg.
Methyltestosterone	2.5 mg.

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fourths of them, it amounts to an actual raise in the plan's income ceilings.

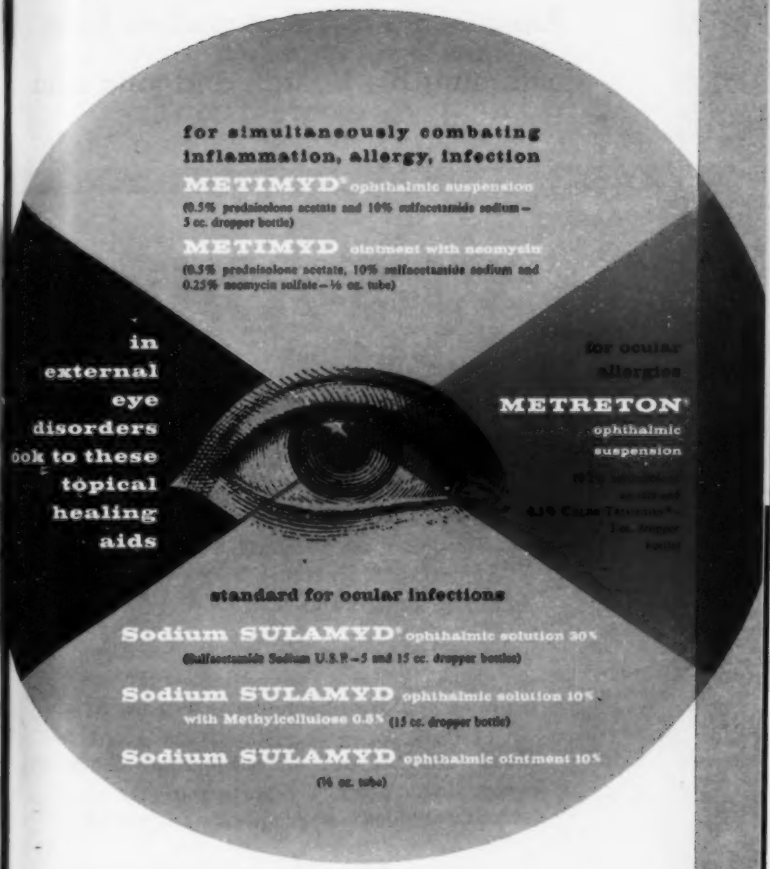
The change eliminates full-service benefits for "approximately 5 per cent of the employed population," according to the president of the Honolulu society, Dr. T. Nishigaya. Whether this will bring any side reactions, the doctors don't yet know.

Tax-Wise Ways to Give To Medical Schools

It's natural that doctors are "more keenly aware of the plight of our medical schools than anyone else," observes Thomas J. Cunningham, general counsel to the University of California. Yet it's unnatural that doctors are doing so little about it:

According to a recent report of the National Fund for Medical Education, he notes, corporations and foundations are now giving *more* money to medical colleges—but individual physicians are giving *less*.

How come? Because, Cunningham thinks, "the average physician is not as aware of the legal techniques of philanthropy as is the average businessman or corporation. In other words, he is uncertain of what steps to take to aid medical education and at the same



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Enhanced absorption of **iron**

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Measurable as well as **subjective** results in your "tonic patients"—particularly the adolescent, convalescent, pregnant and geriatric.

Available: In 8 fl. oz. bottles, specially treated to avoid damage to 'Vi-Sorbin' from light.

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How the revolutionary new Absorption Enhancement Factor was discovered

While conducting a long-range study of Vitamin B_{12} serum levels in several groups of patients, Chow of The Johns Hopkins University found that one group consistently showed surprisingly high B_{12} levels. Investigation revealed that these patients were receiving an experimental oral vitamin preparation made by Smith Kline & French.

After many months of investigation, the factor responsible for the enhanced B_{12} absorption was identified. It was found to be D-Sorbitol—an agent that had been included in the formulation as a sweetener and pharmaceutical stabilizer.

Further investigation brought forth a discovery of equal, or perhaps even greater, significance: this **Absorption Enhancement Factor** produced its effect not only on B_{12}, but also on iron.

Smith Kline & French Laboratories,
Philadelphia

time obtain substantial tax benefits."

The California attorney goes on to suggest three tax-wise ways of giving money:

1. *Set up a short-term trust.* "You irrevocably convey assets in trust for a period of at least two years," he explains, "with instructions to pay the income to a particular . . . medical school, and [in] time to return the principal to yourself or your estate. The advantage of such a trust is that for the years of the trust its income is excluded from your [taxable] income, but you have not parted with the principal permanently."

2. *Give property that has increased in value.* "It is much to your advantage to make a gift of [such] property itself rather than to sell it and then to donate the proceeds," Cunningham points out. "By giving the property, you can deduct its full present value . . . [without becoming] liable for any capital gains tax."

3. *Leave money in your will.* "Death tax advantages are substantial for a physician who includes medical schools or foundations in his will," Cunningham emphasizes. If, for instance, your taxable estate is $200,000 and you bequeath $25,000 to a medical school, "this amount comes off the top of the estate, eliminating it from the impact of the highest rate of taxation." The total tax on such an estate is reduced by $7,500; as a result, "the actual cost to your estate of the $25,000 gift is $17,500."

Medical Society Sponsors Insured Investment Plan

Many mutual funds offer to reduce their sales charges when an investor buys their shares in large lots. Many insurance companies offer life insurance that permits an investor to attain his investment goal even if he dies prematurely. These two offers have been taken up by the Fairfield County (Conn.) Medical Society, to be included in a novel retirement plan for local doctors.

It began as a group investment plan, without the insurance feature. Then several doctors said they'd participate only if insurance coverage were added. So Dr. M. David Deren, committee chairman, began asking insurance men about the possibilities of getting the requested coverage at group rates.

Several companies turned him down. They felt they didn't have enough actuarial data to underwrite such coverage on doctors only. But finally three carriers agreed to split the coverage. So now Fairfield County's doctors may insure themselves for up to $30,000 at group rates. A "statement of health" is required—but

when you treat infections in patients such as these

- debilitated
- elderly
- diabetics
- infants, especially prematures
- those on corticoids
- those who developed moniliasis on previous broad-spectrum therapy
- patients on prolonged and/or high antibiotic dosage
- women—especially if pregnant or diabetic

the best broad-spectrum antibiotic to use is

MYSTECLIN-V

Squibb Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin) — Sumycin plus Mycostatin

for practical purposes, Mysteclin-V is sodium-free

for "built-in" safety, Mysteclin-V combines:

1. Tetracycline phosphate complex (Sumycin) for superior initial tetracycline blood levels, assuring fast transport of adequate tetracycline to the infection site.

2. Mycostatin—the first safe antifungal antibiotic—for its specific antimonilial activity. Mycostatin protects many patients (see above) who are particularly prone to monilial complications when on broad-spectrum therapy.

Capsules (250 mg./250,000 u.), bottles of 16 and 100. *Half-Strength Capsules* (125 mg./125,000 u.), bottles of 16 and 100. *Suspension* (125 mg./125,000 u.), 2 oz. bottles. *Pediatric Drops* (100 mg./100,000 u. per cc.), 10 cc. dropper bottles.

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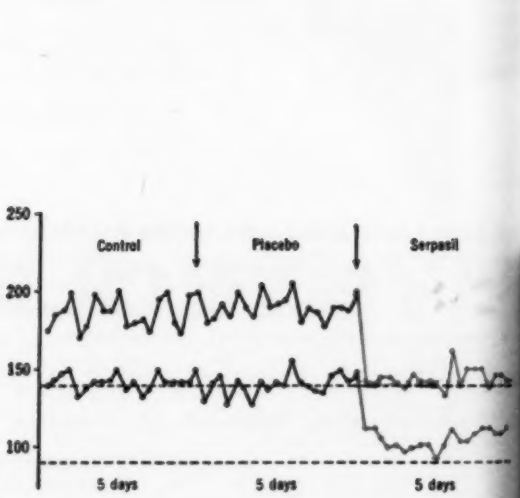


*Chart shows actual response to Serpasil in a patient with benign essential hypertension (data on request). Consider Serpasil® (reserpine CIBA) (1) alone to lower blood pressure gradually and safely in most cases of mild to moderate hypertension; (2) as a primer in severe hypertension before more potent drugs are introduced; (3) as a background agent in all grades of hypertension to permit lower dosage and thus minimize side effects of other antihypertensives. **C I B A**

not necessarily a medical examination.

Here's how the insurance coverage ties in with the investment plan:

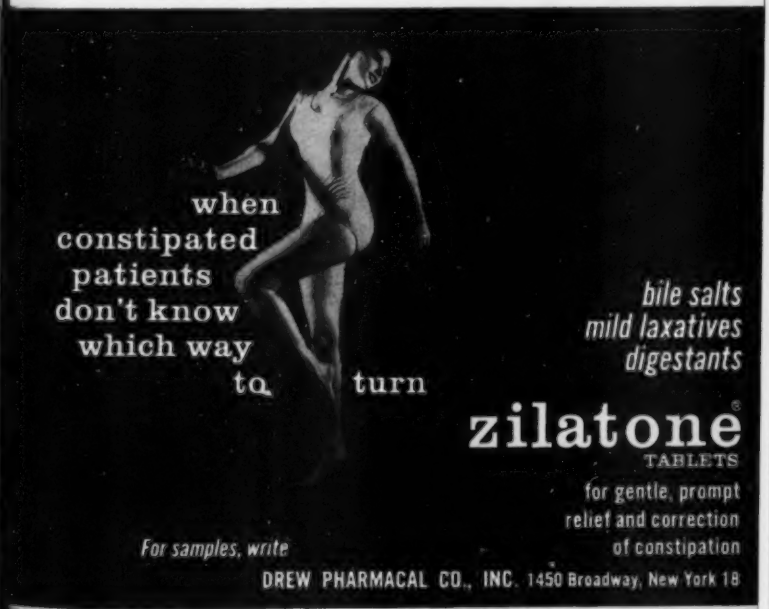
Suppose a doctor elects to invest $30,000 over a ten-year period. If he buys the insurance, then dies before he buys all the mutual fund shares he'd contemplated, the insurance completes his payments at his death. Thus his estate is sure to get at least $30,000 worth of mutual fund shares.

The face amount of the insurance decreases each year as the doctor approaches his investment goal. The premiums decrease, too. On a ten-year, $12,000 investment plan, insurance premiums are about $100 the first year, less than $10 the last.

In its first year, some seventy-five doctors signed up with the Fairfield County retirement plan. "When we added the insurance," Dr. Deren reports, "the number of our subscribers jumped to more than 100."

Britain May Restrict the Supply of New Doctors

In a controlled medical economy, Britons are now debating how much to control the doctor supply. The debate started with the recent report of a Government-appointed



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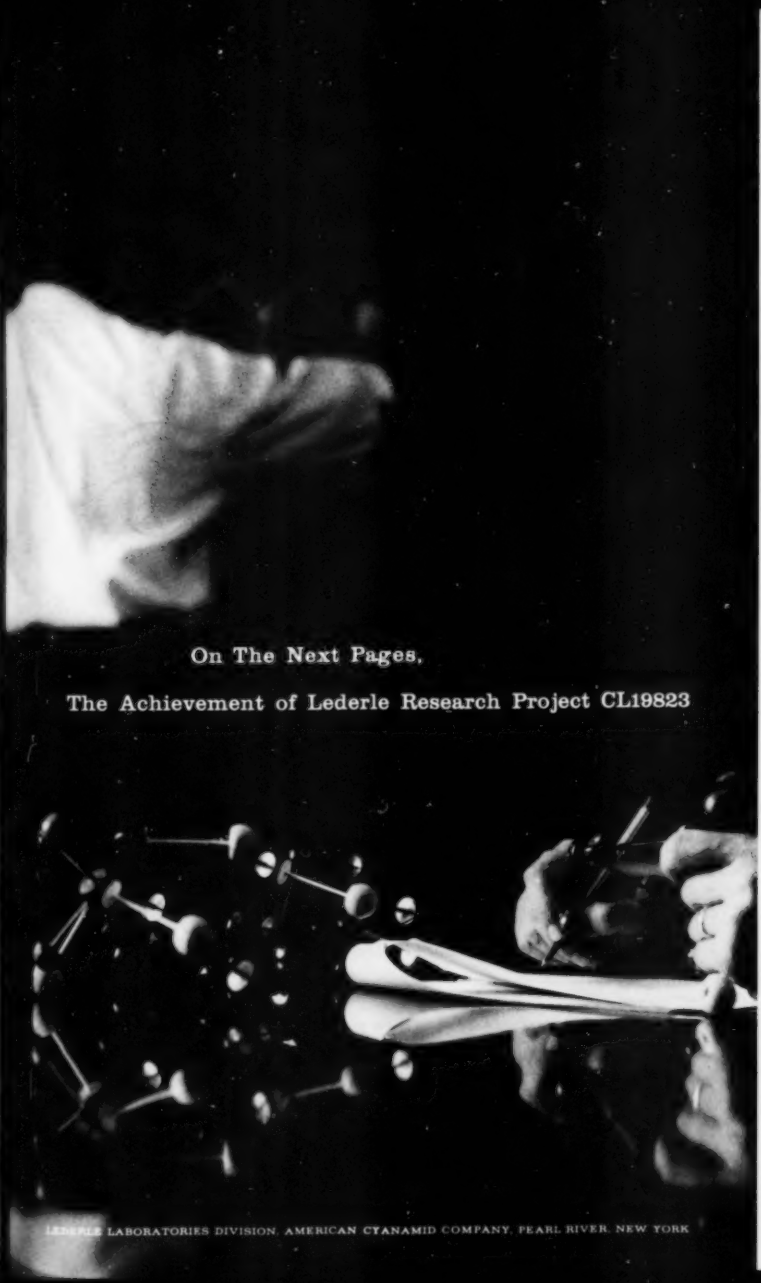
group headed by Sir Henry Willink, set up three years ago to consider Britain's future medical needs. The Willink Committee's chief recommendation: Medical-student intake should be reduced by about 10 per cent.

Since 1910 the population of Great Britain has increased by about 25 per cent. Meanwhile, the doctor population has gone up nearly 80 per cent. Result, according to the British Medical Journal: "a growing feeling . . . that perhaps too many doctors were being trained for too few openings in the future . . . The feeling was accentuated by the difficulties of promotion being experienced by hospital junior staff [doctors] and the lack of openings for general practice in some parts of the country . . . It was the Willink Committee's task to find out the facts."

But now that the committee has made its recommendation, many doctors are unhappy with it. The British Medical Association notes that the increased proportion of doctors "reflects . . . a greater demand for doctors' services." And it adds: "Whatever the result of the arithmetical calculations, the Association would be opposed to the setting of an upper limit to the number of entrants to the profession."

The only real limit on medical service in Britain is "what the country is prepared to spend on it," the British Medical Journal concludes. END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The Achievement of Lederle Research Project CL19823
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Lederle announces a major drug with great new promise

Aristo

a new corticosteroid created to minimize the
major deterrents to all previous steroid therapy

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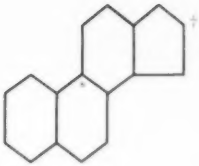

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Triamcinolone LEDERLE
9 alpha-fluoro-16 alpha-hydroxyprednisolone

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◊ **a new high** in anti-inflammatory effects with lower dosage (averages 1/3 less than prednisone)

◊ **a new low** in the collateral hormonal effects associated with all previous corticosteroids

- ◊ No sodium or water retention
- ◊ No potassium loss
- ◊ No interference with psychic equilibrium
- ◊ Lower incidence of peptic ulcer and osteoporosis

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Biological Effects of Aristocort

with

particular emphasis

on:

Kidney function

Animal studies on ARISTOCORT[1] have not demonstrated any interference with creatinine or urea clearance. Autopsy surveys of organs of animals on prolonged study of this medication have shown no renal damage.

Sodium and water

ARISTOCORT produced an increase of 230 per cent of water diuresis and 145 per cent sodium excretion when compared to control animals.[1] Metabolic balance studies in man revealed an average negative sodium balance of 0.8 Gm. per day throughout a 12-day period on a dosage of 30 mg. per day.[2] Additional balance studies showed actual sodium loss when ARISTOCORT was given in doses of 12 mg. daily.[3] Other investigators observed significant losses of sodium and water during balance studies and that those patients with edema from some older corticosteroids lost it when transferred to ARISTOCORT.[4, 5] In two series of patients with various rheumatic disorders (194 cases) on prolonged treatment, sodium and water retention was not observed in a single case.[6, 7]

Potassium and chlorides

Excretion of potassium or chloride ions did not occur in animals given maintenance doses of ARISTOCORT 25 times that found to be clinically effective.[1] Potassium balance studies in humans[2, 3] revealed that negative balance was not observed even on doses somewhat higher than those employed for prolonged therapy in rheumatoid arthritis. Hypokalemia, hyperkalemia or hypochloremia did not occur, when tested, in 194 patients with rheumatoid arthritis who were treated for over 10 months.[6, 7]

Calcium and phosphorus

Phosphate excretion in animals[1] was not changed from normal even with amounts 25 times greater (by body weight) than those known to be clinically effective. Human metabolic balance studies[3] demonstrated that no change in calcium excretion occurred on dosages usually employed clinically when the compound is administered for its anti-inflammatory effect. Even at a dosage level twice this, slight negative balance appeared only for a short period.

Protein and nitrogen balance

Positive nitrogen balance was maintained during a human metabolic study on maintenance dosage of 12 mg. per day.[3] At dosages two to three times normal maintenance levels,

positive balance was maintained except for occasional short periods in metabolic studies of several weeks' duration.[2,3]

There was always a tendency for normalization of the A/G ratio and elevation of blood albumin when ARISTOCORT was used in treatment of the nephrotic syndrome.[8]

Liver glycogen deposition and inflammatory processes

An intimate correlation exists between the ability of a corticosteroid to cause deposition of glycogen in the liver and its capacity to ameliorate inflammatory processes.

In animal liver glycogen studies, relative potencies of ARISTOCORT over cortisone of up to 40 to 1 have been observed. Compared to ARISTOCORT, five to 12 times the amount of prednisone is required to produce varying but equal amounts of glycogen deposition in the liver.[1]

Most patients show normal fasting blood sugars on ARISTOCORT. Diabetic patients on ARISTOCORT may require increased insulin dosage, and occasional latent diabetics may develop the overt disease.

Anti-inflammatory potency of ARISTOCORT was determined by both the asbestos pellet[1] and cottonball[9] tests. It was found to be nine to 10 times more effective than hydrocortisone in this respect.

Gastric acidity and pepsin

The precise mode of ulcerogenesis during treatment with corticosteroids is not known. There is much experimental evidence for believing this may be related to the tendency of these agents to increase gastric pepsin and acidity—and this cannot be abolished by vagotomy, anticholinergic drugs or gastric antral resection.[10] Clinical studies[11] of patients on ARISTOCORT revealed that uropepsin excretion is not elevated. Further, their basal acidity and gastric response to histamine stimulation were within normal limits.

Central nervous system

The tendency of corticosteroids to produce euphoria, nervousness, mental instability, occasional convulsions and psychosis is well known.[12] The mechanism underlying these disturbances is not well understood.

ARISTOCORT, on the contrary, does not produce a false sense of well being, insomnia or tension except in rare instances. In the treatment of 824 patients, for up to one year, not a single case of psychosis has been produced. It appears to maintain psychic equilibrium without causing cerebral stimulation or depression.

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The Promise of Aristocort in Reduction of Side Effects

It has become axiomatic to affirm that the undesirable collateral hormone effects of corticosteroids increase in frequency and severity the higher the dosage and the longer they are administered.

The treatment of rheumatoid arthritis with steroids appears to result in the highest incidence of side effects. For this reason, the side effects associated with ARISTOCORT therapy in 292 patients with rheumatoid arthritis are below compared to the reported incidence of those from prednisone and prednisolone.

Peptic Ulcer

The most recent study available on the incidence of peptic ulceration in patients with rheumatoid arthritis on long-term prednisone therapy reported 12 ulcers in 49 cases (24 per cent).[1] Lowest incidence of 6.5 per cent has been recorded in a group of patients on this drug for six to nine months.[2] Four of six ulcers, in another series of 39 patients on prednisone,[3] appeared in less than three months of therapy.

The occurrence of peptic ulcer in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is approximately 1 per cent (two of the three occurred in patients transferred from prednisone). In the remaining 532 cases recently analyzed, only one ulcer has been discovered in a patient who apparently had no ulcer when changed from another steroid.

Osteoporosis and Compression Fractures

The incidence of compressed fractures of vertebrae is high in patients on prolonged therapy with all previous corticosteroids.[4] One group of 49 patients[1] on long-term prednisone treatment experienced nine vertebral fractures (18 per cent); another series of 39 developed eight such fractures (20 per cent),[3] four to 15 months after treatment began.

The occurrence of osteoporosis with compression fracture in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT, is 0.33 per cent (1 case[5]). Although these results are encouraging, determination of the true incidence of osteoporosis will have to await the passage of more time.

Euphoria and Psychosis

The euphoria so commonly produced by corticosteroids has seemed a most desirable attribute to patients. In penalty, they have often later to pay for this by mental disturbances, varying from mild and transitory to severe depression and psychosis,[4] and toxic syndromes producing even convulsions and death.[6]

Since the onset of these complications is not directly related to duration of steroid administration,[7] the fact that not one case of psychosis occurred in 824 patients treated with ARISTOCORT, is most encouraging.

Sodium Retention—Hypertension—Potassium Depletion

When 17 patients were changed from prednisone to ARISTOCORT, 11 rapidly lost weight although only one had had visible edema.[8] Sodium and water retention, hypokalemia and steroid hypertension did not appear in 194 rheumatoid arthritis patients treated with ARISTOCORT.[5, 9]

The interrelation between blood and body sodium, and steroid hypertension has long been generally appreciated.[10, 11] Except in rare instances, or when unusually high doses are used (e.g., leukemia), edema and hypertension caused by sodium and water retention, has been eliminated with ARISTOCORT.

Minor Side Effects

Collateral hormonal effects of less serious consequence occurred with approximately the same frequency as with the older corticosteroids.[5] These include erythema, easy bruising, acne, hypertrichosis, hot flashes and vertigo. Several investigators have reported symptoms not previously described with corticosteroid therapy, e.g., headaches, light-headedness, tiredness, sleepiness and occasional weakness.

Moon facies and buffalo humping have been seen in some patients on ARISTOCORT. However, ARISTOCORT therapy, in many instances, resulted in diminution of "Cushingoid" signs induced by prior therapy. Where this occurs, it may be related to reduced dosage on which patients can be maintained.

Reduction of dosage by one-third to one-half

In a double-blind study of comparative dosage in patients with rheumatoid arthritis,[12] 70 percent of the cases were as well controlled on a dose of ARISTOCORT one-half that of prednisone. As a general recommendation, ARISTOCORT can be used in doses two-thirds that of prednisone or prednisolone in rheumatoid arthritis.

Comparative studies indicate reduced dosage of ARISTOCORT in bronchial asthma and allergic rhinitis (33 per cent),[8] and in inflammatory and allergic skin diseases (33-50 per cent).[13, 14]

General Precautions and Contraindications

Administration of ARISTOCORT has resulted in a lower incidence of the major serious side effects, and in fewer of the troublesome minor side effects known to occur with all previously available corticosteroids. However, since it is a highly potent glucocorticoid, with profound metabolic effects, all traditional contraindications to corticosteroid therapy should be observed.

There is one overriding principle to be observed in the treatment of any disease with ARISTOCORT. *The amount of the drug used should be carefully titrated to find the smallest possible dose which will suppress symptoms.*

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XUM

The Promise of Aristocort in Rheumatoid Arthritis

ARISTOCORT *therapy has been intensely and extensively studied for periods up to one year on 292 patients with rheumatoid arthritis.*

And significant is the fact that most patients were severe arthritics, transferred to ARISTOCORT from other corticosteroids because satisfactory remission had not been attained, or because the seriousness of side effects had made discontinuance desirable.

Results of treatment

Freyberg and associates[1] treated 89 patients with rheumatoid arthritis (A. R. A. Class II or III and Stage II or III). Of these, 51 were on ARISTOCORT therapy from three to over 10 months. In all but a few patients, satisfactory suppression of rheumatoid activity was obtained with 10 mg. per day. Thirteen were controlled on 6 mg. or less a day, and for periods to 180 days. The investigators reported therapeutic effect in most cases to be A. R. A. Grade II (impressive) and that marked reduction in sedimentation rates occurred.

Another interesting observation: Of the 89 patients treated, 12 had active ulcers, developed from prior steroid therapy. *In six patients, ulcers healed while on doses of* ARISTOCORT *sufficient to control arthritic symptoms.*

Hartung[2] treated 67 cases of rheumatoid arthritis for up to 10 months. He found the optimum maintenance dose to be 11 mg. per day. Nineteen of these patients were treated for six to 10 months with an "excellent" therapeutic response.

Dosage and course of therapy

Initial dosage recommended is 14 to 20 mg. per day—divided into four parts and given with meals and at bedtime. Anti-rheumatic effect may be evident as early as eight hours, and full response often obtained within 24 hours. This schedule should be continued for two to three days, or until acute manifestations of the disease have subsided.

The maintenance level is arrived at by reduction of the daily dosage in decrements of 2 mg. every three days. Range of maintenance has been found to be from 2 mg. to 15 mg. per day—with only an occasional case requiring as much as 20 mg. per day.

The aim of corticosteroid therapy in rheumatoid arthritis is to suppress the disease only to the stage which will enable the patient to carry out required activities of normal living or to obtain reasonable comfort. Maintenance dose of ARISTOCORT to achieve this end is arrived at while using other established means of controlling the disease.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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Medical Economics

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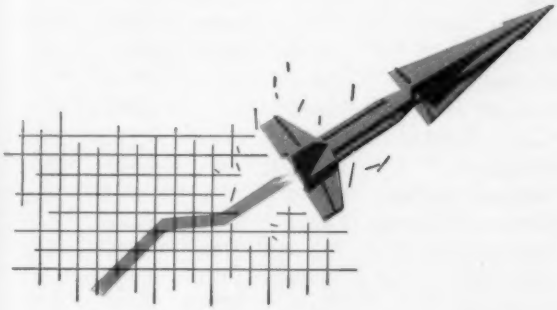

Are Missile Stocks A Good Bet?

By Sidney Berman

With all the uproar over missiles and the billions to be spent for them, you're probably wondering whether you ought to invest in companies that are likely to profit from the boom. And if so, which companies?

Obviously, missile stocks today should be an excellent investment. But they're also speculative. Some may never get off the ground. Others may double or triple or quad-

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How Fifty Missile Stocks Have Performed

1. Aircraft

Company	Recent Price Range: Oct. 3, 1957[1]	Dec. 31, 1957	Jan. 28, 1958	1957 Dividend
Bell	13½	15¼	16⅜	$1.00
Bendix	47⅞	44½	48¼	2.40
Boeing	34½	37⅞	38⅛	1.00[3]
Chance Vought	26½	30	35	1.60
Chrysler	74⅜	52¾	54⅜	3.00[2]
Curtiss Wright	34¼	24	25½	3.00
Douglas	59⅞	70⅛	64⅞	2.00[2]
Fairchild Engine	7½	6⅝	8	None
General Dynamics	49⅝	59⅝	60⅛	2.00
General Tire	23	27⅝	27¾	.70
Grumman	18⅛	17¾	18	1.75
Lockheed	32¼	38⅜	41¼	2.40[3]
Martin	27⅝	32½	32¾	1.60[3]
McDonnell	23⅞	22⅜	24⅞	1.00[3]
North American	21¼	30½	30	1.60[2]
Northrup	19¾	22	23	1.60
United	63½	52¾	53⅝	3.00[3]

[1]Day before first sputnik. [2]Also extra dividend. [3]Also stock dividend.

ruple their present worth in a few years.

How can you pick the winners? There's no foolproof system, naturally. Some 200 firms are listed as primary contractors for the twenty-eight assorted missiles now in production and for others being developed. No one can tell for sure which of these companies will come out on top. Yet there's a solid clue to the long-term possibilities of any missile stock: the apparent

civilian potential of the firm.

In other words, the companies that figure to profit most in the long run are those that can transform defense-developed techniques and materials into new commercial products and services for the consumer. That means new sources of propulsion and heat and light, new textiles and drugs and building materials, new electronic and chemical and metallurgic miracles.

With this in mind, let's begin by considering the four industrial groups into which missile companies may be classified. Then we'll discuss some specific stocks. First, the four groups:

1. AIRCRAFT. This is the most speculative of the four. New missile contracts could be offset by cutbacks in production of conventional aircraft. What's more, the industry has traditionally been plagued by poor cost-estimates, contract cancellations, and rapid obsolescence of its products.

In the immediate future, profits are expected to be smaller in most companies. Many leading investment firms recommend only those aircraft companies whose products are well diversified.

2. CHEMICALS AND FUELS. This group has very bright long-term prospects. The high-energy solid fuels used to power rockets produce 40 to 60 per cent more propulsion efficiency than do petroleum-based fuels. Thus, the solid fuels may revolutionize transportation.

Their major ingredients are lithium hydroxide and boron (which comes from borax). Boron is already widely used in agriculture and in the manufacture of glass, plastics, detergents, ceramics, and enamel. At least three major oil companies are using it as a gasoline additive. So the stocks of the suppliers and processors of these chemicals seem to be fine growth prospects.

The 'Brains'

3. ELECTRONICS. Electronic systems are the "brains" of missiles, and they represent half the cost. So by 1961 six or seven billion dollars may be spent annually on missile electronics. Other defense items could pour billions more into the industry. And in this field especially there's vast promise for eventual civilian application of techniques and products inspired by the national defense program.

MORE ▶

How Fifty Missile Stocks Have Performed

2. Chemicals and Fuels

Company	Recent Price Range: Oct. 3, 1957[1]	Dec. 31, 1957	Jan. 28, 1958	1957 Dividend
Air Reduction	51⅝	50¼	53⅝	$2.50
Amer. Metal Climax	20	17¼	19	1.20
American Potash	43¾	38¾	39½	1.00[3]
Dow Chemical	53⅝	52⅞	57⅛	1.20[3]
du Pont	180¾	176⅜	185	6.50
Food Machinery	52	47⅜	50¼	2.00
Foote Mineral	48⅝	39⅛	40	.80[3]
Gulf Oil	132⅜	107¼	109½	2.50[3]
Hercules Powder	39	41¼	40	1.10
Hooker Electro.	24⅜	24½	27	1.00
National Distillers	81½	20⅝	22¼	1.00[3]
Olin Mathieson	44¾	38⅞	41⅝	2.00
Pennsalt Chemical	56½	50¼	55¼	1.60[2]
Phillips Petroleum	41⅛	36⅝	39½	1.70
Stauffer Chemical	59¾	68¾	62½	1.80[3]
Thiokol Chemical	57½	75⅛	43⅛	3.10
U.S. Borax	44	42	44¾	.60

[1]Day before first sputnik. [2]Also extra dividend. [3]Also stock dividend.

4. METALS AND SUPERALLOYS. Though there are lots of question marks in this group, long-term growth possibilities appear very good. Experts say no one metal or alloy is likely to predominate in missiles. With air frames constituting no more than 20 per cent of a missile's weight, some authorities doubt that missiles will soon open up a major market for any metal.

Right now, the chief metals involved in the missiles program

appear to be stainless steel, titanium, and magnesium. But these may well be superseded by superalloys containing chromium, nickel, molybdenum, beryllium, and columbium. They promise big profits *in the future* because of their still unexplored potentialities for civilian use.

Eleven Key Firms

So much for the four main industrial groups in the missile field. The following is an alphabetical rundown on eleven stocks that seem worth your attention for the reasons given above. They're by no means the only possibilities. The accompanying tables list a total of fifty stocks that experienced investors believe offer good long-term prospects.

American Potash & Chemical once produced heavy chemicals only. But it has grown into a highly diversified chemical company. It produces one-fourth of the total U. S. output of boron chemicals. It owns a majority interest in American Lithium Chemicals, Inc.—one of the nation's three largest lithium producers. And it plans to enter production of high-energy fuels in the near future. Late last month, its stock was selling at around 40. Dividend paid in 1957: $1, plus a 3 per cent stock dividend.

Brush Beryllium, one of the nation's two beryllium producers, was recently awarded a five-year $23,000,000 contract by the Atomic Energy Commission for 500,000 pounds of the metal. Beryllium is three times stronger and much lighter than steel; and it's heat-resistant to 1,500 degrees Fahrenheit. The Air Force plans an all-beryllium supersonic fighter plane and has recently given Brush a pilot contract to develop a process that will produce sheet beryllium for planes and missiles. The company's stock, traded over-the-counter, has been selling at around 13. No dividends were declared in 1957.

Mighty Backlog

Douglas Aircraft has a billion-dollar defense backlog, a third of it for missiles. It also has a billion-dollar civilian backlog, said to be the biggest in the industry, composed largely of orders for DC-8 jet transports. Its stock now sells at around 65. Dividend paid in 1957: $2 regular, plus $2 extra.

MORE▶

How Fifty Missile Stocks Have Performed

3. Electronics

Company	Recent Price Range: Oct. 3, 1957[1]	Dec. 31, 1957	Jan. 28, 1958	1957 Dividend
American Bosch	18	20	20¾	$1.05
Borg Warner	36¼	27¾	28½	2.40
Eastman Kodak	95¾	98⅞	101	2.60[2]
Emerson Electric	25½	30⅜	31½	1.60
General Electric	62	61½	63½	2.00
Minn.-Honeywell	88⅝	83½	78¼	1.60[2]
Motorola	45	40¾	39	1.50
Raytheon	19⅝	21⅞	22⅛	None
Robert Fulton	29⅛	21⅞	24½	1.50
Sperry Rand	20	18⅛	19⅜	.80
Thompson Products	56⅞	49⅜	47½	1.40
Westinghouse	60⅜	63½	63⅞	2.00

4. Metals and Super Alloys

Allegheny Ludlum	40⅝	30⅛	33½	2.00
Avco Manufacturing	6⅛	5⅝	6⅞	.10
Brush Beryllium	11	12½	13½	None
Reynolds Metals	46⅞	33⅜	35⅝	.50[2]

[1]Day before first sputnik. [2]Also extra dividend. [3]Also stock dividend.

Foote Mineral produces a diversified list of ores, metals, alloys, and chemicals. It's one of the three biggest U.S. producers of lithium, a missile-fuel ingredient. And the company has a five-year contract with the Atomic Energy Commission to supply lithium hydroxide. The stock has been selling at around

40. Dividend in 1957: 80 cents, plus a 2 per cent dividend paid in stock.

General Dynamics is playing a big part in the defense program, including a major role in missiles. In addition, its civilian business is flourishing and promises to grow. The company produces the Atlas ballistic missile and two anti-aircraft guided missiles. Its Convair division makes the B-58 supersonic jet bomber, two supersonic jet interceptors, and the new 880 jet transport. Its Stromberg-Carlson division makes electronic equipment for missile-guidance systems. And Stromberg-Carlson also manufactures gear for telephone companies. The parent company's Electric Boat division builds atomic-powered subs for the Navy. Finally, the recently acquired Liquid Carbonic division is a major producer of liquefied gases. As of late last month, General Dynamics' stock was selling at around 60. Dividend paid in 1957: $2.

Maybe a Wait

General Tire and Rubber is the nation's largest producer of missile rocket-motors (through its Aerojet General subsidiary). Because of increased capitalization, the company's per share earnings have taken a dip recently. So you might have to wait a long time for good returns from the stock. But it could pay off quite well as an investment planned to provide you with a retirement income. Its current price: around 28. Dividend paid in 1957: 70 cents.

Not Just Liquor

National Distillers & Chemical Corp. is the second largest liquor maker in the U.S. But it has also branched out into chemicals, plastics, metals, and high-energy fuels. Though it didn't enter the chemical field until 1949, the company was getting a third of its earnings from chemicals by 1956. National is now going into the production of titanium, and it has an active research program in the boron-fuel field. In 1956 the Atomic Energy Commission awarded it a five-year contract to supply 2,000,000 pounds of zirconium annually. Its stock has been selling at around 22. Dividend paid in 1957: $1, plus 2 per cent stock dividend.

Sperry Rand makes electronic instruments for civilian use as well as for missiles, aircraft,

antiaircraft weapons, etc. Its sales ($871,000,000 for fiscal 1957) are expected to top a billion dollars this year. The stock has recently sold for around 19. Dividend paid in 1957: 80 cents.

The Martin Company has an $800,000,000 backlog of orders, more than half of it for missiles. Martin seems assured of an extension of its airplane business, probably in the form of Navy orders for Sea Master jets. Influenced by the trend toward increasingly complex weapons, the company is apparently considering mergers with other aircraft concerns and electronic companies. Stock has been selling at around 33. Dividend paid in 1957: $1.60, plus 5 per cent stock dividend.

Desert Refinery

U.S. Borax & Chemical controls about 70 per cent of the nation's borax deposits. So it should be a leader in the field of high-energy fuels. Last November, it opened a $20,000,000 borax refinery in the Mojave Desert, site of the world's biggest sodium borate deposits. The stock has recently sold at around 45. Dividend paid in 1957: 60 cents.

Westinghouse Electric may appeal to the doctor who's cautious but who wants to get into new investment fields. The concern already has a substantial backlog of orders and a strong position in electronics and atomic energy. It can be expected to grow even stronger as nuclear energy and electronic systems for missiles become everyday facts. The stock now sells at around 64. Dividend paid in 1957: $2.

The Long View

The foregoing eleven firms are close to the top of the heap at the beginning of the Space Age. But don't forget that large-volume production of missiles is still some time off. Meanwhile, research and development are eating into current profits. Which is why missile investments may yield slim returns for a few years.

It's tough to predict the sales-earnings trend for many of the companies I've named. So the wary doctor may prefer to invest only in those with substantial backlogs and sound past-performance records. And he'll probably limit his stake in missiles to a fraction of his total investments. END

What Medicare Won't Pay You For

Make sure you know before treating a serviceman's dependent. Here are the claims most often denied

By Clifford F. Taylor

In its first year, the Armed Forces Medical Care Program for Military Dependents—"Medicare" for short—has paid out over $28,000,000 to over one-fourth of the country's private physicians. The program has reimbursed doctors for 388,671 claims, averaging out to $71 a claim.

But it has *refused* to honor hundreds of other claims that individual practitioners submitted.

In some cases, confusion over what Medicare will and won't pay for stems from ambiguity in the Government's regulations. There are still plenty of bugs to be ironed out. But the program's directors insist most of the claims they've rejected have been turned down for only one reason: The doctors apparently hadn't read the rules.

Even if you haven't yet had a Medicare case, you're likely to run up against a few before long. So you'll do well to familiarize yourself with the regulations. That

way, you'll avoid making rash promises to patients—and perhaps losing both money *and* patients as a result.

The following examples of rejected claims are authentic ones. Since they're also pretty typical, you'll want to make a mental note of the reason for each rejection. If you do, you probably won't make similar mistakes.

Office Operation

Case #1: A small-town G.P. recommended an immediate tonsillectomy for the 12-year-old daughter of a Navy radioman. The nearest hospital was forty miles away. The child's mother spoke up about the inconvenience and added expense she'd face if the doctor insisted on hospitalizing the girl. So he did the operation in his office. And Medicare refused to foot the bill.

Reason: Under Medicare rules, only maternity and injury cases are eligible for out-patient treatment by private physicians at Government expense. Says a spokesman for the program: "This is a basic and clearly stated principle. But a misunderstanding of it on the part of many doctors has been the greatest single reason for claim denials."

Case #2: A surgeon operated on a Marine sergeant's wife for breast cancer. Three weeks after the operation, the woman's doctor asked for a chest X-ray. Both the operation and the X-ray were paid for by Medicare. But when the doctor requested another chest X-ray several months later, Medicare wouldn't pay for it.

Reason: The program pays up to $50 for postoperative tests and diagnostic procedures directly related to the surgical procedure for which a patient was hospitalized. The first X-ray qualified because it was to check for abnormalities that might have resulted from the surgery. The second X-ray didn't qualify because it was considered a routine check of the patient's medical condition, not directly related to the surgery.

Patient Pays Part

Case #3: An Army warrant officer's 5-year-old son fell and injured his right elbow. The boy's mother took him to a neighborhood G.P. The doctor X-rayed the child's arm, found no fracture, and applied an elastic bandage. He expected Medicare to pay the $10 bill, since non-hospitalized injury cases are covered

by the program. But his claim was denied.

Reason: In accident cases that aren't hospitalized, the patient must pay the first $15 of the doctor bill. Only the balance (if any) will be paid by Medicare, up to the limits provided in its fee schedules.

Work-Up Claim Denied

Case #4: After an office work-up, a G.P. decided that the Navy ensign's wife had pneumonia. He had her admitted to a hospital and treated her there. When he sent his bill to Medicare, he included the charge for the office work-up. This portion of the claim was denied.

Reason: The diagnostic work-up had not been followed by referral to a specialist for hospitalization. Medicare *does* pay for an office work-up that's a preliminary to surgery. Even if you simply examine the patient in your office, then refer the case to a specialist, you'll be paid for a termination visit by Medicare. In this instance the G.P. followed through on the case himself. So Medicare said the first office visit was the patient's responsibility.

Case #5: While an Air Force lieutenant was on leave, he and his wife had an auto accident. They were taken to a near-by hospital. There a doctor treated the lieutenant for two fractured ribs, his wife for head cuts and body bruises. He submitted his claim for treating the couple to Medicare. But only part of it was allowed.

Reason: Medicare pays only for servicemen's dependents. The doctor should have sent a separate bill for the lieutenant himself to the nearest Air Force Base Surgeon.

Active Status a 'Must'

Case #6: An obstetrician undertook maternity care of a Navy man's wife. Two months before the child was born, the woman's husband retired from active duty. The doctor delivered the baby and gave the mother post-natal care. But Medicare denied the greater part of his claim for complete maternity care.

Reason: The program covers treatment of eligible dependents of active duty personnel only. In this instance, it refused to pay for treatment given after the husband retired from active service.

Case #7: A psychiatrist referred an Army corporal's wife to a plastic surgeon. In the psychia-

trist's opinion, the woman's emotional troubles were caused partly by self-consciousness about the size of her nose. So a plastic operation seemed indicated. The surgeon did the job and took it for granted Medicare would pay. But it wouldn't.

Reason: The rules don't permit payment for nose reshaping, harmless mole removal, or other purely cosmetic or elective surgery. In fact, they exclude all "elective medical and surgical treatments." Had rhinoplastic surgery been required for an acute medical condition, Medicare would have paid.

Out-Patient Extraction

Case #8: An internist hospitalized an airman's wife for acute pyelitis. Believing the kidney infection might be aggravated by an abscessed wisdom tooth, he called in a dentist for consultation. The dentist confirmed his belief that the tooth was abscessed and agreed that it should be removed as part of the pyelitis treatment. But he didn't have time to pull it then and there. Since the patient was eager to end her hospital stay, the internist permitted her to go home.

A few days later, she went to the dentist's office and had the tooth extracted. The internist had assured both her and the dentist that Medicare would pay the bill. After all, the procedure was clearly related to her pyelitis. He was very much embarrassed when the claim was rejected.

Reason: Medicare doesn't cover out-patient dental care. If the doctor had kept the woman in the hospital until the tooth was removed, the dentist's claim would have been honored.

New Manual Will Help

In reporting these cases, Maj. Gen. Paul I. Robinson, Executive Director of Medicare, admits the regulations aren't perfect. But they're being clarified. The armed forces have now published a "Medicare Manual and Schedule of Allowances" for the use of state medical associations and disbursing agents.

The 247-page manual includes explicit information on allowable and nonallowable procedures in a number of categories. So it's a good book to consult whenever you're in doubt as to whether or not Medicare will honor a given claim.

In a nutshell, the manual says a dependent is eligible for Medi-

care only (1) as a hospital inpatient, or (2) immediately before or after hospitalization for bodily injury or surgical operation. Within and outside the hospital, a female dependent can get complete obstetrical and maternity services.

Specifically excluded from coverage are (1) chronic diseases; (2) nervous and mental disorders, except for diagnostic purposes; (3) "elective" procedures; and (4) "treatment normally considered to be out-patient care." **END**

"Unfortunately, our main speaker came down with laryngitis this afternoon . . .

But he had the foresight to make a tape recording of his speech!"

TAKE A LESSON FROM

16. *The Case of*

By Xavier F. Warren

EDITOR'S NOTE: *Here's the sixteenth in a series of true incidents selected from the confidential file of a malpractice insurance company's claims adjuster. Although identifying details have been changed, the stories accurately portray recent cases.*

Unlike some other malpractice insurance policies today, Dr. Walter Slape's covered him for libel. Lucky for him it did, too. Otherwise it could have cost him plenty to learn the lesson my company paid for: Never write moral judgments into medical reports on patients.

Dr. Slape is a private orthopedist with a part-time industrial practice. Three mornings a week, he visits a large factory. There's an employe in this plant's shipping department named Jack Holbert. At 35, Jack's still as fun-loving as the middle Rover Boy.

One day during the lunch hour, Jack decided it would be fun to climb a jumbled pyramid of crates piled in the yard. He was halfway to the top when, to the delight of his audience, a crate slipped and Jack came tumbling down. He picked himself up, grinned, and started back up. Just then the whistle blew.

the Hurt Malingerer

Jack didn't do any work that afternoon. He kept saying, as if it were quite a joke, "Oh, my aching back!" The next day he didn't show up. The following day he did. But instead of going to the shipping department, he went directly to the plant infirmary.

That morning Dr. Slape had left town for a three-week vacation. To the sympathetic young G.P. who was filling in, Jack complained of pain in his back, his neck, and his head. The G.P. could find no real injury. But Jack did have a reddened shoulder and a couple of minor bruises. So the G.P. cautiously prescribed no work and physiotherapy, the treatment to be continued until the aches subsided.

Jolly Jack had a great time on his visits to the physiotherapy room. He rolled his eyes at the pretty masseuse and gaily offered to massage *her*. Somehow, though, he didn't seem to get better. He still complained of aches and pains as the days became weeks.

Jack was drawing $40 weekly in compensation pay, pending final determination of his disability. That suited him just fine. He was unmarried, lived with his parents, and had a way of supplementing his income at the races —a pursuit now unhampered by work.

Then Dr. Slape got back from vacation. The day he

did, Jack strolled into the plant infirmary for his regular progress check. He told the doctor he could scarcely drive a car, so severe was the pain in his neck. When tested, he grunted and groaned and showed marked impairment of motion.

Dr. Slape is a conscientious orthopedist. And he gets mad when somebody tries to euchre him.

So he promptly testified to the industrial commissioner that Jack was an out-and-out malingerer. And he wrote the same thing in his report to the compensation carrier.

The commissioner pondered. Finally he agreed with Jack's attorney that Jack was no malingerer but a hypochondriac—and awarded him twenty additional weeks of compensation!

Price of Free Speech

The attorney next set his sights on bigger game: He started a libel action against Dr. Slape for $50,000.

The doctor's testimony to the industrial commissioner was privileged, so he couldn't be sued for what he'd said there. But the letter he'd sent to the compensation insurance company—that gave him no such immunity. He'd dictated it to a factory stenographer, and it had been read by a file clerk in the insurance company. Thus, technically, Dr. Slape had called Jack a malingerer right out in public.

They Played It 'Safe'

Our attorney advised us to settle. He said the question as to whether the man was a malingerer or a neurotic would be entirely up to the jury to decide—and you never can tell what a jury will do.

Besides, Dr. Slape would have been an uncertain witness. The huge damages asked by the plaintiff made the doctor overconfident. As he saw it, the amount was clearly absurd; therefore the whole case was clearly absurd. He was absolutely right, of course. But an attitude like that can play right into the hands of a plaintiff's attorney.

We settled out of court for $2,200. And nowadays, when Dr. Slape finds a faker, his report reads: "I am unable to find anything to account for his complaints." We know what *that* means. And it doesn't mean legal trouble for the doctor. END

Six Questions About Your Safe Deposit Box

There are plenty of catches to renting one. Here are some facts that will help you to avoid possible legal tangles • *By Joel Berg*

When you put your possessions in a modern safe deposit box, they're protected from fire, theft, and every other major menace except one: *you.*

Some doctors apparently forget that a lease of a safe deposit box is a legal contract. It grants certain rights and responsibilities to both you and the bank. And your state tax department has still other rights.

If you pay too little heed to those rights and responsibilities, you may be jeopardizing your valuables instead of safeguarding them when you put them in the vault. So here's a run-through of the main points you ought to consider in renting or maintaining a box:

1. *Who can enter your safe deposit box?*

The answer's up to you. Leases can be drawn to permit entry by only one owner, by the owner and his deputy, by two or more joint owners, by any member of a partnership, etc. There's a wide variety of special provisions to meet your particular wants.

You get the most privacy from a lease that permits only you to enter the box, of course. But such an arrangement has its disadvantages. For instance, if you find you need certain papers when you're ill or out of town, it may be impossible for you to get them.

That's why many doctors name trustworthy persons as deputies. The deputy is empowered to enter the box at any time. But you can't just telephone your bank and name a deputy whenever you suddenly realize you need one. You've got to do it in person. So you'd better not wait till you *are* sick in bed to give some thought to the matter.

Deputies Are Limited

And remember that the deputy can't enter the box after your death. It's no good to appoint your wife as deputy in the hope that she'll thus have access to your belongings when you die. It doesn't work that way.

On the other hand, *joint* rental does give either of you the right to enter the box after the other's death—once the tax authorities have released it. But many banks discourage joint boxes for this reason: They're loaded with potential legal tangles.

What's 'Joint' About It

Trouble is, many people believe that the property in a jointly held box belongs to the survivor if the other box-holder dies just as it does in a joint bank account. But they're wrong. The only thing that's joint is the right to enter the box. Its contents are another matter. So here's the sort of thing that can happen under such an arrangement:

When a Wyoming man named John K. Hartt died in 1952, his safe deposit box was opened and found to contain $1,500,000 in securities. His will left part of the money to his five daughters, but his wife claimed it all. She argued that since she could have entered the jointly held box and taken the securities while Hartt lived, the money should still be hers. It took three years of legal jockeying and untold thousands of dol

lars in court costs to convince her she was wrong.

Partnership boxes involve a similar risk. So if you have such a box, you'll do well never to put personal property in it—not even as a temporary measure.

After You're Gone

2. *What will happen to your safe deposit box when you die?*

Under the laws of almost all states, safe deposit boxes are sealed at the death of a holder. This is true, remember, even with jointly held boxes. Yours may remain closed until it has been inventoried and released by inheritance-tax officials. So it'll probably be several days before your family or your executor can remove the contents.

Courts in some states will issue special search orders to permit immediate removal of certain items—such as wills, burial instructions, and insurance policies—from safe deposit boxes. (Incidentally, your bank will tell you exactly what items can be withdrawn in your state on the death of a box holder. It will also estimate how long the delays are likely to be.)

As you know, the state's concern with a deceased man's box isn't idle curiosity: The contents are appraised for inheritance-tax purposes. If the value of the contents is large enough, Federal estate-tax authorities will also take an interest. And if the box contains an unusual amount of cash, the Internal Revenue Service may have a few questions to ask.

All of which suggests several precautions you ought to take in order to prevent tie-ups at your death:

¶ If anybody else's property is stored in your box, it should be clearly indicated. Keep proof of ownership either in the box or in some other place where it's readily available.

¶With jointly held boxes, the tax authorities presume that everything belonged to the first person who dies. So, once again, ownership should be clearly marked. And proof of ownership should be right there in the box.

¶ If the box contains items of no value—shares of defunct corporations, for example—proof that they're valueless should be clipped to them.

¶ If you do keep a lot of cash in your box, better have a note of explanation along with the green stuff. Such a note may save

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your heirs some needless controversy.

3. *Who will get the property in your safe deposit box?*

The only thing governing the passage of property in a safe deposit box is the deceased's will (if he leaves one) or the state's law of descent and distribution. Once the contents are released to the executor, it's up to him to distribute them according to your wishes. Moral: Make your wishes known. And make them precise.

There *are* doctors who use the safe deposit box as a kind of substitute or supplementary will. They drop a watch in an envelope addressed to Uncle John "for his kindness and encouragement." They confidently expect Uncle John to get the keepsake some day.

There's a good chance he never will. The courts have repeatedly refused to recognize the legal force of such informally ticketed legacies.

Nor, as I've said, is a joint box a substitute for a will. The contents go to your estate to be

"You're right, by golly, I do owe you a $2,700 medical bill. I plumb forgot all about it."

distributed among your heirs. They don't automatically go to the surviving box-holder.

What to Keep There

4. *What should you put in your safe deposit box?*

Legally, you can put in anything but explosives and narcotics. But in deciding what you *should* keep there, ask yourself the following questions about a given item:

Is it confidential? Would it be hard or expensive to replace? Does it have great cash or sentimental value? Do you want to make sure it's discovered after you die?

If the answer to any of the above questions is yes, the item probably belongs in your safe deposit box. Among the things you should seriously consider keeping there:

¶ Evidences of property (stocks, bonds, mortgages, deeds, bank books, insurance policies);

¶ Important legal records (contracts, partnership agreements, adoption papers, passports);

¶ Jewelry and highly valued keepsakes;

¶ Important personal papers (receipts, war service records, marriage certificates, birth certificates).

If you prefer to keep your will in the box, make sure your executor knows it's there. And it's wise to leave a copy of it elsewhere—preferably either with the executor or with your attorney. The same goes for your burial instructions, if any.

One item that probably belongs in the box is an inventory of all your possessions, including dates of purchase and costs. In case of fire or theft in your home or office, such a list would be invaluable for insurance purposes. (Conversely, it's a good idea to keep an inventory of the contents at home or in the office.)

Maximum Security

5. *How safe are safe deposit boxes?*

Very safe, indeed. Only holders' keys can open the lock once it's set. You can't open the box without first presenting the key and identifying yourself; the bank can't open it without you or your authorized deputy at hand. Only by court order can the box be opened against your will.

Today's vaults have every

conceivable protection against fire, bombs, and the safecracker's torch. And the bank can be held legally liable for the contents of your box (unless it can prove that it did not deviate from practices which would make theft virtually impossible). So the chances of loss seem infinitesimal.

6. *How much do safe deposit boxes cost?*

You can rent a small box (2″ x 5″ x 22″) in the average city for $4 to $8 a year, plus 10 per cent Federal tax. Per cubic inch, your safe deposit box is probably the most expensive piece of property you'll ever rent. But it's well worth the price you pay. It's also worth the time and effort it takes to insure that you're using it wisely. END

Liver Regulator

As a new interne in the medical clinic, I was seeing my first return-visit patients. It was a depressing experience. Each patient seemed worse off than before, in spite of the treatment I'd prescribed on the previous visit. As the morning dragged on, I listened to their complaints with an increasing feeling of discouragement.

Clinic hours were almost over when a middle-aged woman came up to me. Wearily, I asked her: "And how do *you* feel?"

"Just fine, Doctor," she chirped. "I've never felt better in my life."

My spirits surged. Here, at last, was a patient who proved I *wasn't* a washout as a physician. "That's just wonderful," I said. "I'm certainly glad my prescription helped you so much."

"Oh, I didn't take your medicine," she said cheerfully. "I went over to the drugstore and got me some of Dr. Hitchcock's Liver Regulator. It fixed me up just fine."

—CARL E. SHROAT, M.D.

For each previously unpublished anecdote accepted, MEDICAL ECONOMICS *pays $25 to $40. Address: Anecdotes, Medical Economics, Inc., Oradell, N.J.*

Higher Fees for The Nuisance Patient?

If he's too demanding, he ought to pay extra for your time and energy, says this writer

By Chester Porterfield

Every practice has its share of nuisance patients. The first such patient I came across had fastened himself to an internist who was one of my early clients. He used to come late for appointments, bedevil the office staff, read his prescriptions out loud, call the doctor in the evening to see if the medicine the pharmacist had given him was the right color, and—oh, you know.

My client told me he had a number of characters like this; they'd hang onto him like leeches. He even had a name for them: Joe Clinch (or sometimes Mrs. Joe Clinch).

Joe Clinch barges in when he isn't expected and makes noisy demands for immediate service. He telephones t.i.d. He wants the latest medicines, including the one

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THE AUTHOR *is vice president of Medical Management Control, San Francisco.*

touted for the first time in this morning's tabloid. He has a sister, a cousin, and an aunt, all of whom are enchanted by Joe's symptoms, and all of whom demand that the doctor take them into his confidence.

What should you do about these time- and energy-consuming Joe Clinches? Well, if you're justified in charging less to a scrubwoman or a poor clergyman, it seems to me you've got an equal right to impose a surcharge on Joe.

The Earmarks

You can usually recognize the nuisance patient on first contact. He has cased the office in advance, and he knows a lot about you—including your regular fees. He wants everything diagramed. He breathes down your neck as you write an Rx. He wants you to tell him the pharmacist's probable fee. (And if you fall into *that* trap, he makes both you and the druggist wish you hadn't.) He complains about other doctors who didn't understand his case. He has somehow wormed your home phone number out of an otherwise cautious answering service.

Many doctors who have learned to recognize those symptoms take an immediate step to cope with them: They let the patient know in advance that they may have to charge him above-average fees. They do it tactfully, making the surcharge sound like a compliment, not an insult.

There's a Difference!

Insult: "I'll have to charge you $5 per office visit instead of my usual $4, Mr. Clinch. You see, I expect you to take up so much of my time . . ."

Compliment: "Because of the unusual nature of your case, Mr. Clinch, you're going to take more of my time than an ordinary patient. So you'll understand that I can't afford to take your case at my usual fees."

But what if you identify the nuisance patient only after you've been committed to the case? I advise my clients, in such an event, to sit down with Joe Clinch and say: "You're going to need a lot more time and attention than we anticipated. You've noticed that already, I'm sure. So I'll have to bill you at higher-than-average rates, since you're decidedly a different-from-average patient. While I value our detailed phone conver-

sations, they do tie up the line when other patients are trying to get me. So I'll also have to bill you for each phone call . . ."

Their Saving Grace

Surprisingly enough, not only do most of the Clinches accept the *idea* of higher fees, but their delinquency rate is likely to be low. When we first observed this in practice analysis, we used to wonder why such difficult characters weren't delinquent debtors as well. But now we know:

Such persons demand special services from almost everyone they deal with. And except for doctors, no one would dream of offering special services without special fees too. An occasional Clinch *will* break off the relationship when presented with the surcharge. But if so, what has the doctor lost? Not much!

The only real problem for the physician, I've found, is in deciding just how big his surcharge should be. Seems to me the answer must depend on the case at hand. I know one surgeon who increases his surgical fee by 25 per cent when he learns in advance that a patient is a member of a large, excitable, and insistent family. The reason: The doctor guesses from experience he'll probably have to deal out large doses of psychotherapy to the family throughout the postoperative course.

Most of the time, his guess turns out to be a good one. And I've seen surcharges of from 50 per cent to 200 per cent that didn't seem unreasonable, considering the difficulties the patients themselves created.

But note that I'm *not* advocating that any doctor raise his fees for the medically difficult case. Clinch doesn't *need* extra care. He just demands it. END

"No, Mrs. Overstraw, your appointment slip says you must give *at least* twelve hours' notice to cancel, not *exactly* twelve hours."

Whatever your field of practice, you'll find food for thought in the latest estimates of minimum M.D. population ratios for 22 specialties—and in the reasons why they vary *By William N. Jeffers*

How Big a Population to S

Because of growing competition in large cities, more and more specialists are setting up practice in less crowded areas. If you're toying with the idea yourself, you need the answer to this question:

What's the smallest population a full-time specialist in your field can draw from and still earn a good living?

Naturally, there's no precise answer. Every community has certain qualifying factors apart from its population (e.g., its economic stability, its per capita income, its educational level). You've also got to consider its drawing power as a medical, shopping, and business center for surrounding areas. And the number of local referring physicians is vital to any specialty that's dependent on referrals.

...to Support a Specialist?

Still, there can be *approximate* answers. To get them, MEDICAL ECONOMICS has asked leaders in each key specialty to estimate the minimum population needed to support one full-time specialist in their particular field of practice.

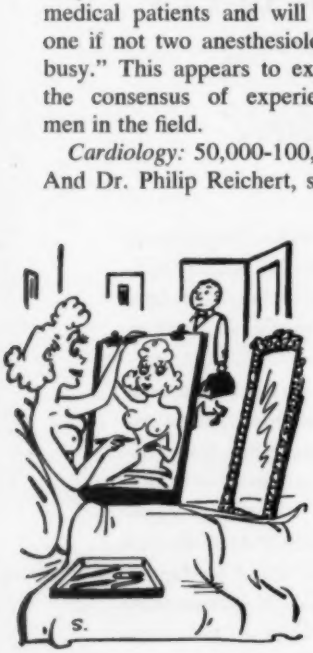
In the following paragraphs, minimum figures for each of twenty-two fields have been compiled from their responses. Where the figures are given as a range, they represent the range of estimates from authorities with differing opinions.

Allergy: 20,000-25,000. Says Dr. John Sheldon, professor of internal medicine at the University of Michigan: "The allergist is likely to have more work in a community where there are large groups of white-collar workers. And

he should have available a good lab for bacteriologic analyses."

Anesthesiology: The important factor here isn't lay population. It's the size of the hospital and the number of surgical procedures performed there. "As a rough guide," says Dr. Curtiss Hickcox, secretary of the American Board of Anesthesiology, "a hospital with seventy to a hundred beds will have more surgical and obstetrical than medical patients and will keep one if not two anesthesiologists busy." This appears to express the consensus of experienced men in the field.

Cardiology: 50,000-100,000: And Dr. Philip Reichert, secretary of the American College of Cardiology, adds the following bit of advice: "A cardiologist almost has to be near a big university hospital. Something new is breaking all the time. Unless a man can keep abreast of such developments, he can't practice cardiology as he should."



Look for Factories

Dermatology: 20,000-50,000. Dr. James R. Webster, president of the American Academy of Dermatology and Syphilology, observes that the *kind* of population is almost as important as its *size*, "An industrial area offers more opportunities than a rural section with the same-size population, since there's likely to be more dermatitis where there are factories. Another thing to consider is the availability of a medical school, where the dermatologist might teach one afternoon a week. But hospital facilities aren't usually as important in this field as in some others."

They Need G.P.s

Endocrinology: 250,000. Here, too, the doctors emphasize the value of being near a university hospital in order to keep up

with rapid clinical developments. And Dr. Henry H. Turner, secretary of the Endocrine Society, points out that there should be a preponderance of G.P.s in the locale. Reason: The G.P. isn't generally set up to do his own endocrine work; whereas many specialists, such as gynecologists and urologists, are.

Gastroenterology: 100,000-250,000. Also required, according to most of the men queried by MEDICAL ECONOMICS: a hospital with a good laboratory and X-ray facilities and at least 300 beds.

General Surgery: 10,000. This low figure has proved itself adequate, says one of the queried surgeons—an officer of the Pacific Coast Surgical Association: "A number of my former residents at Stanford are working in such areas, and they've all done eminently well."

Internal Medicine: 10,000-25,000. Internists agree that the minimum population needed depends largely on the number and activity of G.P.s in the area. But Dr. Lewis T. Bullock, chairman of the American Society of Internal Medicine, offers an easier rule of thumb: "Any town big enough for a surgeon, an ear-nose-throat man, and a urologist is also large enough for an internist."

Hospitals Important

Neurosurgery: 100,000-150,000. Dr. Leonard T. Furlow, secretary of the American Board of Neurological Surgery, adds the following comment: "A neurosurgeon who locates in a small community might find his time taken up with diagnostic study, treatment of central nervous-system trauma, and so forth, while important surgery such as brain tumors might go to a near-by major community. Adequate hospital facilities, competent anesthesiologists, and specialists in other fields *have* to be available to the neurosurgeon."

How to Tell

Neurology: 50,000-100,000. An additional criterion suggested by Dr. Russell N. De Jong, editor of the journal Neurology: "If internists and orthopedic surgeons are doing well in a given locale, a neurologist should do well too, since most of his work would be referrals from those men."

Obstetrics/Gynecology: 5,000-10,000. Says Dr. John I.

XUM

Brewer, secretary of the American Gynecological Association: "For an OB/Gyn. man, a population of 5,000 is adequate and one of 10,000 is a certainty. Some young men I know who've settled in small towns have added partners in a year to keep up with the demand." But while Dr. Robert L. Faulkner, secretary-treasurer of the OB/Gyn. board, agrees that a population of 5,000 *could* support an obstetrician, he places the minimum for gynecology at 10,000. "And," he adds, "you need good hospital facilities, which exist in many places for obstetrics but not for gynecology."

Eye Men Everywhere

Ophthalmology: 5,000-25,000. Observes Dr. Frank W. Newell, head of ophthalmology at the University of Chicago: "The size of the population needed to support a full-time ophthalmologist seems to be steadily decreasing, judging from the number of board-certified men practicing in small places." And Dr. Merrill J. King, secretary of the American Board of Ophthalmology, who puts the minimum population at 15,000, observes: "Another consideration should be the availability of reliable optical service."

Orthopedic Surgery: 25,000-75,000. Both these figures can be justified, according to one of the queried doctors. "If the general surgeons in the area turn over the fracture work to the orthopedist," explains Dr. George O. Eaton, of Baltimore, "a busy locality of 25,000 is plenty big enough to suport one orthopedic surgeon. Otherwise, a population of 75,000 is needed." And Dr. Donald E. King of San Francisco warns that city size may not be as important a consideration as drawing area. "At least 50 per cent of my patients come to see me in the city from small towns in the northern part of the state," he reports.

Earnings in ENT

Otolaryngology: 30,000-100,000. "A certified otolaryngologist should net anywhere from $15,000 to $18,000 if he practices in a city of 30,000," says one authority.

And in larger communities it's possible for a beginner to net from $25,000 to $30,000 a year, adds Dr. Harry P. Schenk of the specialty's board. But he warns that "the man who wants to limit

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his practice to either audiology, fenestration and mobilization surgery or nasal, otologic, and larynx plastic procedures is going to need a community of 50,000 to 100,000 population."

Pathology: 15,000-35,000. One pathologist holds with the higher figure on the ground that a man with ten years' experience should net about $25,000 a year —and that he couldn't do it in a smaller community. "And a smaller place probably couldn't support the 150- or 200-bed hospital a pathologist needs," explains Dr. A. H. Dearing, executive secretary of the College of American Pathologists. But another officer of the college reports that he knows of a pathologist who's doing well in a town of less than 13,000.

Follow the OB Man

Pediatrics: 10,000-25,000. Notes Dr. Einor Christopherson, executive secretary of the American Academy of Pediatrics: "If a town is big enough to support even one obstetrician, a pediatrician should do all right there. Obviously it all depends on how many young families there are in the community."

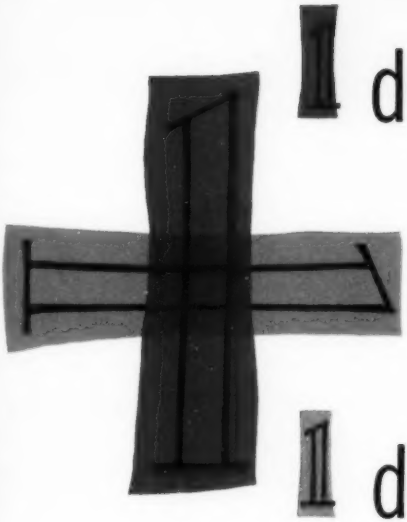
Plastic Surgery: 50,000. Dr. Frank McDowell, secretary of the American Board of Plastic Surgery, adds: "Although the situation is getting tighter in big-city areas, a young plastic surgeon can start practice in almost any smaller community and make a satisfactory living pretty soon."

Hospital Not Vital

Proctology: 25,000-50,000. In this field, much depends on the type of practice you want. As one authority explains it: "The man who does ambulatory proctology requires no hospital and doesn't compete with general surgeons: so a population of 25,000 could support him. The proctologist who limits himself to the anus and rectum but operates only in a hospital would require at least 50,000. And the proctologist who includes colon surgery may need a considerably larger population, since he has to compete with general surgeons, G.P.s, and even with gynecologists."

Where Income Counts

Psychiatry: 25,000-50,000. Here, authorities agree, community income and educational levels are [MORE ON 230]



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Test Your Tax

You'll be less apt to tangle with T-men if you know the answers to questions like the following

By Joseph F. McElligott

You've probably heard that the Treasury is tightening its system for auditing Federal income tax returns. Such reports seem to be true. Some straws in the wind:

Last September, Internal Revenue Service Commissioner Russell C. Harrington announced that the tax-audit system was getting more and more foolproof. Two months later, the Massachusetts Federal tax director revealed that one of the toughest crackdowns ever was under way: Some 200 agents, he said, were working over 18,000-odd selected returns—from which the Government expects to wring millions of additional tax dollars.

So you'll want to be especially careful to keep your 1957 return free of errors. One glaring mistake can subject the entire return (as well as earlier ones) to a thorough investigation. In recent weeks, I've been jot-

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THE AUTHOR *is a tax and medical management consultant in New York City. He formerly worked for the Government as an Internal Revenue agent.*

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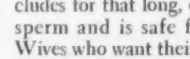

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ing down the questions clients have asked me. Here are a few that seem widely applicable to doctors. If you can *anticipate* the answers, you're not likely to slip up on your own return.

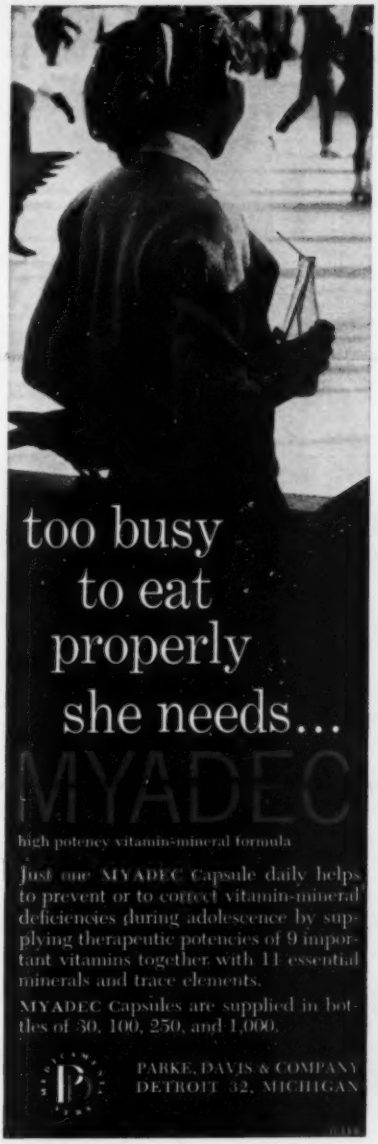
Stock Dividends

In 1957 I got about $500 in dividends from stocks I own in my own name. I know that $50 of this is tax-exempt. But since I file a joint return with my wife, aren't we both entitled to a $50 dividend break, giving us a total dividend exclusion of $100?

No. If you owned the stock jointly, you *could* combine the two $50 exclusions and thus get $100 in dividends tax-free. But when stock is held in the name of one spouse only, the mere fact of filing a joint return doesn't entitle a married couple to two $50 exclusions. (Note, by the way, that on the new tax return for 1957 you must indicate clearly just who owns the stock.)

Private Charity

In her work with a charitable organization, my wife has taken an interest in an unfortunate widow who has two young children and no money. At Christmas she sent the woman a check for $800. Can we deduct this amount as a



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charitable contribution on our joint tax return?

No. Though the action was clearly a charitable one, gifts to private individuals (no matter how needy) aren't deductible under Federal tax law. What your wife could—and probably should—have done was to send the check to the organization itself, asking that it be earmarked for the widow. In that case, the gift would have been deductible.

Prepaid Expenses

My mother entered the hospital in November for what we knew would be a long—and expensive—stay of six months or more. I prepaid her hospital bill through March, expecting that I could include the total amount in my 1957 medical deduction. But one of my colleagues tells me I won't be allowed to include any portion of prepaid expenses that covers 1958 charges. Is he correct?

Yes. In figuring your medical deduction for 1957, you can add in *only* amounts representing expenses actually incurred before Jan. 1. Thus, the actual costs for November and December qualify. But here's a strange quirk in the law: Though you couldn't move your 1958 expenses *back* into the 1957 tax year by prepaying them, you

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could have moved all last year's medical expenses *forward* into the 1958 tax year by postponing payment until after Jan. 1. That's the gist of a recent Tax Court decision on the question of prepaying and postponing medical bills.

Rubber Check

One patient last year paid his $325 bill with a worthless check. He has since left the country, so collection seems impossible. Isn't there some way I can deduct this loss on my tax return—as a bad debt, say, or as a charitable contribution?

Unfortunately, the answer's no. Such losses can be deducted as bad debts only if previously reported as income. And the Government would certainly tighten the screws on any doctor who reported a rubber check as a charitable contribution.

Property Damage

My neighbor's children have trampled down several very expensive imported shrubs in my garden. Since the children's parents refuse to pay damages, may I deduct the value of the shrubbery as a casualty loss?

No. It's true that if equivalent damage were caused by a storm or flood, you'd be allowed to deduct losses not covered by in-

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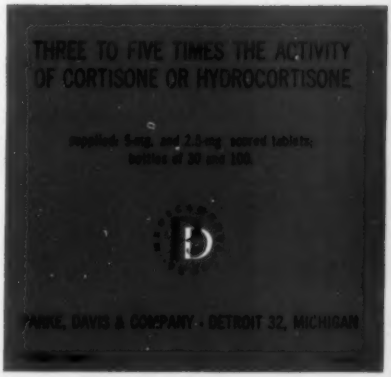


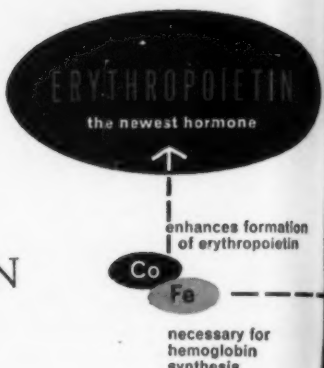
NEW

RESEARCH ON

ERYTHROPOIETIN

EXPLAINS

CLINICAL SUPERIORITY OF



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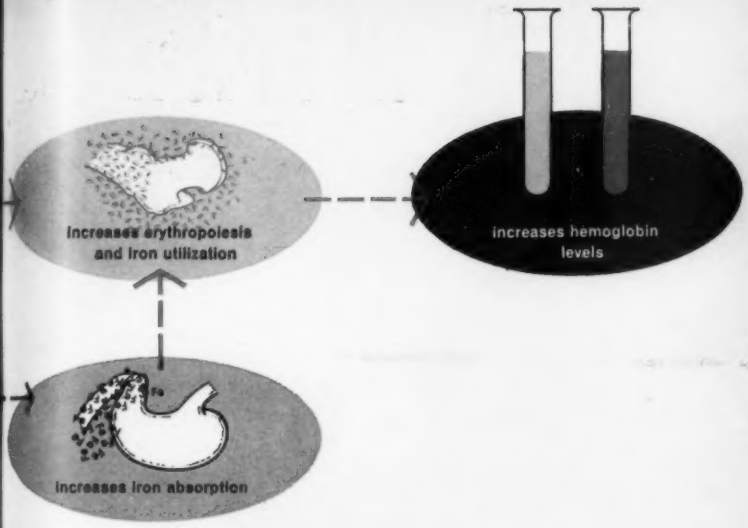

Elucidation of the action of erythropoietin—the erythropoietic hormone—provides a clear explanation for the observations of Holly,[1] Ausman,[2] Tevetoglu[3] and many others who have reported that in the common anemias cobalt-iron therapy results in a clinical response superior to that produced by iron alone.

Increased Iron Absorption and Utilization—Recent investigations show that cobalt enhances the formation of erythropoietin.[4,5] This hormone increases the rate of production of new red cells which, in turn, increases the rate of both iron utilization by the marrow and iron absorption from the intestine.[6]

Clinical Application—In simple *iron deficiency anemia*, 89% of patients treated with Roncovite exceeded 12 Gm. of hemoglobin per 100 cc., while only 33% of the same patients treated with iron alone for a comparable period reached this level.[2] In *anemia of pregnancy*, 98.2% of Roncovite-treated patients maintained their hematologic status; 63.8% delivered with a hemoglobin of 13 Gm. per 100 cc. or more.[1] In *anemia of infancy and childhood* an average hemoglobin level of only 8.7 Gm. per 100 cc. was attained with iron alone while the same patients subsequently reached an average hemoglobin level of 11.6 Gm. per 100 cc. with Roncovite.[3]

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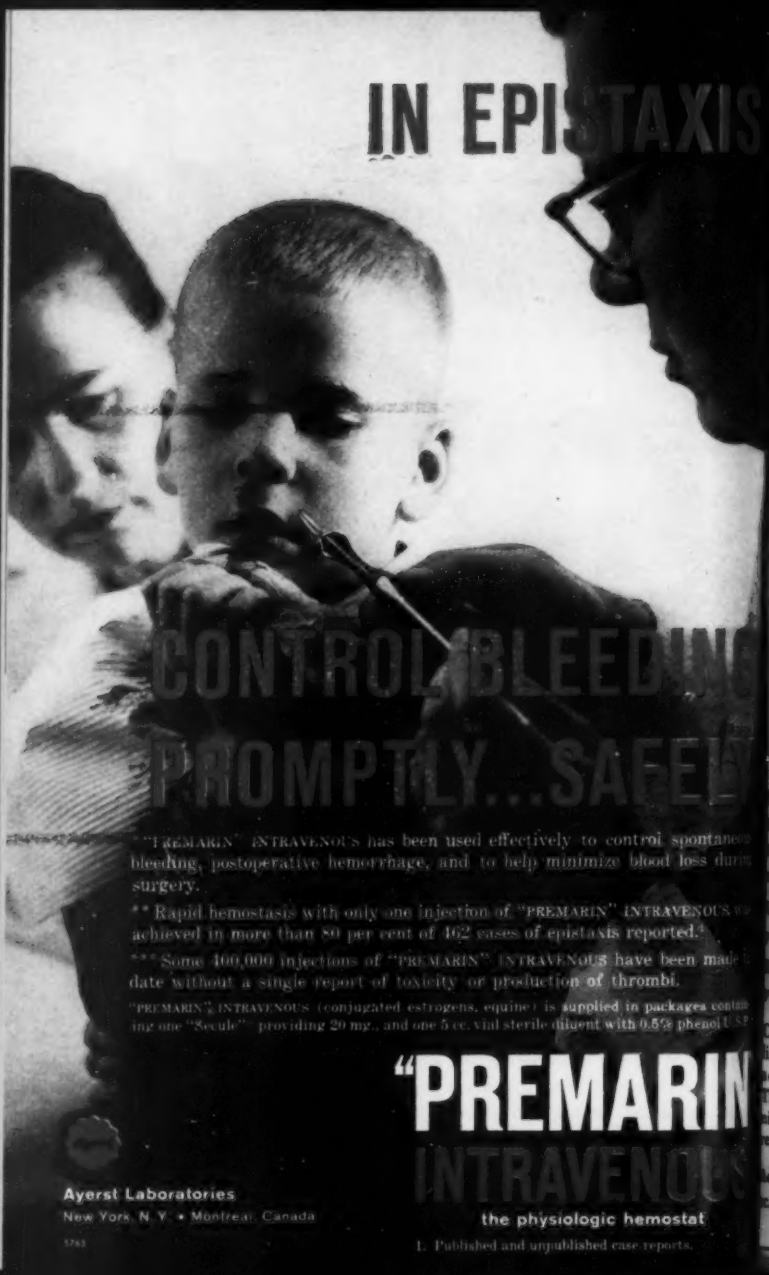
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Sideline Business

In addition to my medical practice I have a small business on the side. Since it lost $1,500 in 1957, may I deduct the loss from my professional income?

The answer depends on whether or not your sideline is *really* a business (in other words, whether you conduct it with the reasonable expectation of making money). If it *is* such an operation, you can deduct its losses from your *other* income. But if it's essentially a hobby (not actually intended as a money-maker), you can't. To illustrate, any sort of practical farming would ordinarily qualify as a legitimate business. But if you breed orchids and spend more on them every year than you make from them, the Treasury would probably regard the deficit as a nondeductible "hobby loss."

Unreported Income

I've always believed that the Government can assess you for additional taxes only within a three-year period after you file a return. But a friend of mine has just been billed for extra taxes on his 1952 return. Has the law been changed?

No. Generally speaking, the Treasury can demand an additional payment only within the three-year period. Thus, the return you file on April 15 of this year won't be subject to challenge after April 15, 1961. But the rule doesn't hold if you understate your income by a *substantial* amount. In such an event, the Government has six years within which it may legally dun you for additional taxes.

What's considered a *substantial* understatement of income? The answer: a reported income that falls short of your actual income by more than 25 per cent. For example, suppose that on April 15, 1958, you report a

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1957 income of $20,000 and neglect to include a $7,000 profit made on a property sale. Your omitted $7,000 profit is more than 25 per cent of your actual income ($27,000). In that case, you can be billed for additional taxes at any time up to April 15, 1964.

Betting Loss

Ordinarily I never wager on anything, but last fall I lost a $100 bet when Navy's football team beat Army. My surgeon friend who won the bet tells me I can cushion the blow by deducting the loss on my 1957 tax return. Is he right?

He's a better football forecaster than tax adviser. You *can't* ask Uncle Sam to "cushion the blow" for you. Briefly, the tax law on betting is this: You must report—and pay taxes on—net gain (total gains minus total losses). But you may not deduct net losses (excess of losses over gains). In your case, there are no betting gains. So you end up with a nondeductible net loss of $100. (One consolation: You can tell your friend that *he* has to report his winnings.) END

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Trouble in th

How does it get started? How can it be stopped? For some new answers, consider this case of friction between hospital board and medical staff

Quite a few doctors will go skiing this winter in New Hampshire's White Mountains. Some of them will practice their Christys in or around North Conway. And an unlucky few may land in the town's fifty-three-bed Memorial Hospital. If so, they'll find it a smooth-running institution.

They wouldn't have found it so a few years ago. Then Memorial Hospital was racked by a classic conflict between its governing board and its medical staff. The board wanted staff doctors to reorganize so that the hospital could gain accreditation. But the staff doctors didn't want to reorganize on the board's terms.

Feelings were too frayed for the North Conway story to be published at the time. Now that it can be told, the unusual way in which the conflict was resolved may well serve as a lesson to doctors in other places. For it was

...e in the Hospital

By Hugh C. Sherwood

non-local physicians—physicians representing the weight and authority of the state medical society—who finally cut the Gordian knot.

How was this possible? Let's start at the beginning:

Back in 1950, Memorial Hospital's twenty-man board of trustees reorganized itself and elected eight new members. Most of the new men were outspokenly concerned about the hospital because its patient load was down, its financial position was poor, and it had never been accredited.

Soon the reorganized board began sending some of its members to visit outstanding hospitals throughout New England. Two years later, their formal report indicated that Memorial suffered greatly by comparison. The hospital, they concluded, had "always operated in a very informal manner . . . All members of the staff [had been] using its facilities with little or no supervision or regard to routine." As a result, the board members said, Memorial offered only fair—in some instances, below-par—professional services.

So they recommended that the medical staff's bylaws

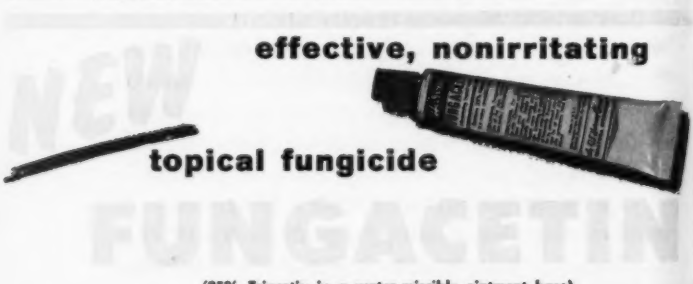
be rewritten to conform with requirements of the Joint Commission on Accreditation of Hospitals. They also urged that the staff be departmentalized, with each department having its own chief.

In effect, this plan would have sheared the then chief of the nine-man staff of much of his power. He was Dr. George Harold Shedd, a general practitioner and surgeon in his seventies who'd practiced in North Conway for over forty years.

Dr. Shedd's prestige within the community was enormous. His family had helped found Memorial Hospital. For years he'd been North Conway's only physician. And he'd been primarily responsible for approving the staff appointments of the other doctors.

Trustees Didn't Agree

But a number of the trustees didn't see eye to eye with him on the matter of hospital administration. They didn't share his dislike of what he called "regimentation." They felt he was needlessly opposed to the requirements of the Joint Com-



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mission. What's more, a few younger medical staff members expressed some sympathy with the trustees' point of view.

But when the chips were down, all the doctors united in support of the chief-of-staff system. And they made it plain they wanted Dr. Shedd kept on as chief.

They *didn't* want a battle, though. As Dr. Kenneth E. Dore, one of the senior staff members, recalls it: "We didn't much like the reorganization plan calling for departmental chiefs, but we saw no reason at first to put on boxing gloves on account of it."

How They Compromised

So the doctors willingly joined the trustees in forming a liaison committee. All through the spring and summer of 1953, it pondered the hospital's problems. And it finally came up with a compromise agreement. Among its terms: The medical staff would be divided into departments. The doctors would periodically elect a president and other officers. And the hospital administrator would attend all staff meetings.

Early in the fall, the doctors approved the plan—with one reservation: They didn't want it made mandatory that the administrator attend their meetings.

The board's reaction came as a surprise. The administrator *would* attend staff meetings, ruled the trustees—and that was that!

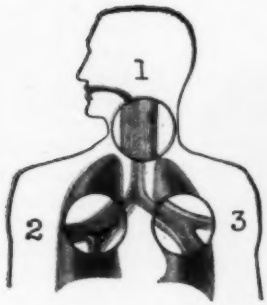
Morale Plummeted

Shortly afterward, the board again took unilateral action—this time, on a matter that had nothing to do with staff reorganization but that none the less seriously affected the doctors' morale:

A young medical staff member—a G.P.—was seeking the right to do internal fixation of fractures in addition to his other privileges. His medical colleagues felt he should have privileges only in general practice and medicine. They so recommended to the board. In protest, the G.P. submitted his resignation. Ordinarily, it would have been considered by doctors and trustees alike. But without consulting the staff, the board met swiftly and voted to accept it.

The by-passed physicians were incensed. They now refused to support any reorganiza-

breaks up cough*



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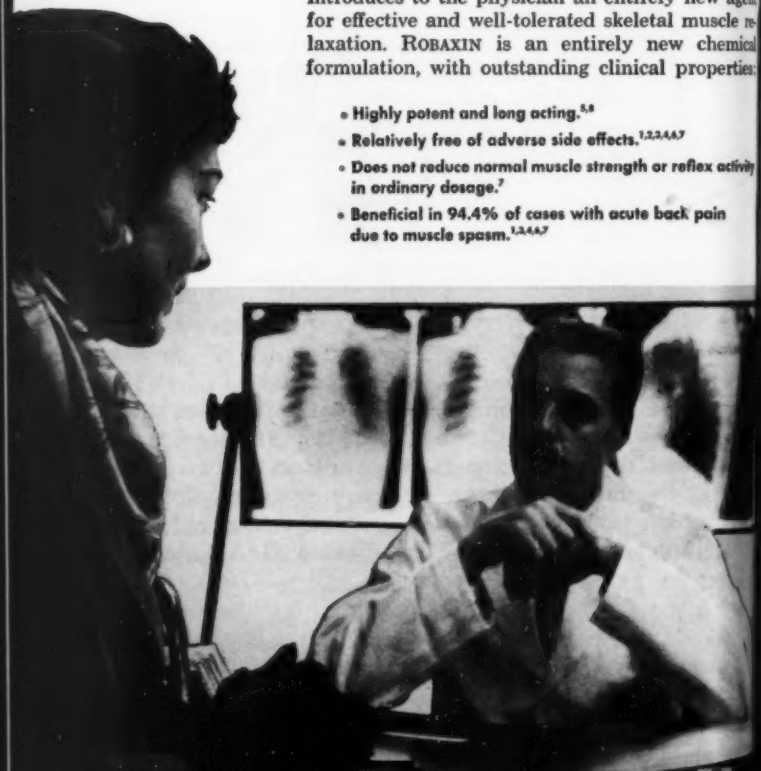

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Dosage – *Adults:* Two tablets 4 times daily to 3 tablets every 4 hours. Total daily dosage: 4 to 9 Gm. in divided doses.

Precautions – There are no specific contraindications to Robaxin and untoward reactions are not to be anticipated. Minor side effects such as lightheadedness, dizziness, nausea may occur rarely in patients with unusual sensitivity to drugs, but disappear on reduction of dosage. When therapy is prolonged routine white blood cell counts should be made since some decrease was noted in 3 patients out of a group of 72 who had received the drug for periods of 30 days or longer.

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References: 1. Carpenter, E. B.: Publication pending. 2. Carter, C. H.: Personal communication. 3. Forsyth, H. F.: Publication pending. 4. Freund, J.: Personal communication. 5. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: American Pharm. Assn. 46:374, 1957. 6. Nachman, H. M.: Personal communication. 7. O'Doherty, D.: Publication pending. 8. Truitt, E. B., Jr., and Little, J. M.: J. Pharm. & Exper. Therap. 119:161, 1957.

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tion plan. And the long-standing friction between board and staff flared into open hostility.

The repercussions were felt throughout the hospital. Some nurses quit to work elsewhere. The patient load fell off still further. The local newspaper implored the trustees to do something fast.

The Board's Ideas

In December, the board broached some new proposals: Let the staff be divided into five departments, with the head of each to be appointed by the staff president in consultation with the trustees. Let the medical records and tissue committee be primarily responsible for most of Memorial's patients.

The doctors disliked this idea. Dr. George V. Spring voiced their misgivings this way:

"A member of this community becomes ill, calls the doctor of his choice, and is admitted to the hospital. The next day, the patient finds that instead of being under the care of the doctor of his choice, he is actually the responsibility of a committee or a chief . . . If this patient hap-

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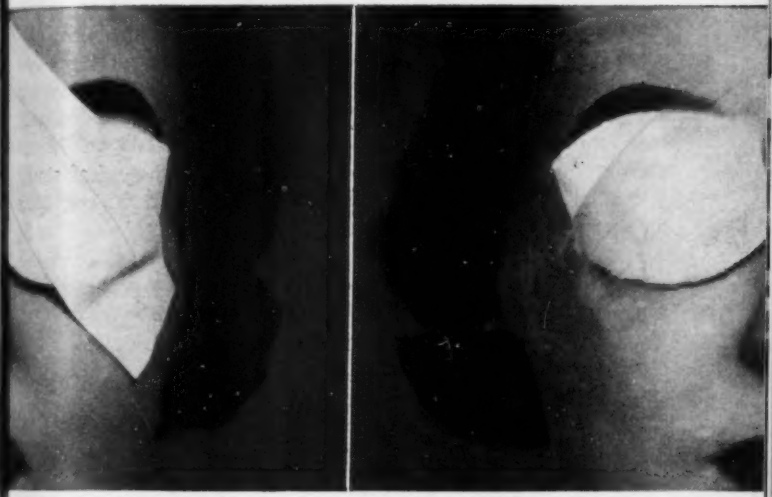

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pened to be one of the trustees or a member of his family, I am sure that he would be the first to protest such intrusion into the confidential doctor-patient relationship."

Dr. Spring recommended that the latest proposals be rejected. And they were. Whereupon the board boiled over. The trustees were legally responsible for the hospital, they told the doctors. Since the medical staff wouldn't act, the board would.

And it did. It established five departments and placed five doctors in charge of them. But only one of the designated men accepted his appointment.

The Doctors' Decision

At a regular staff meeting in February, 1954, the doctors took some unilateral action of their own: They reached a unanimous decision, as Dr. Dore later reported to the trustees, "that the one-chief system as in our present by-laws [is] the choice unqualified." Furthermore, they reaffirmed their desire to have Dr. Shedd continue as their chief.

Within twenty-four hours, the trustees formally restated their belief "that the [departmental] system would be the most efficient and best if it can be put into effect." But whatever system was employed, they added ominously, "Dr. Shedd would not be acceptable as chief of staff."

Thus did board and staff seem to reach the end of the line. So disturbed were the trustees that they reportedly considered issuing an ultimatum to the doctors: Reorganize or get out.

An Offer of Help

A few days later, one of the board members happened to visit the state capital. Since the dispute had become widely known, some business friends asked him about it and advised him to get in touch with the New Hampshire Medical Society. When he did so, society officials said they'd be glad to intervene if they were needed. The board member brought this word back to North Conway.

With no other solution in sight, both groups decided to give the idea a try. So on April 14, 1954, thirteen physician-members of the New Hampshire Medical Society's Council gathered in North Conway's Congregational Church. There, while a spring snow blanketed the

TRICHOMONIASIS TOUCHÉ

In persistent vaginal trichomoniasis of the wife, clinical investigators are unanimous in placing the husband first among possible exogenous sources of re-infection.[1] About 39 to 47 per cent of persistent cases are believed to be re-infections from the sexual partner.[2]

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1. Rogers, G. C., and Fleming, J. M.: Am. J. Obst. & Gynec. *68*:563 (Aug.) 1954. 2. Karnaky, K. J.: Urol. & Cutan. Rev. *48*:812 (Nov.) 1938.

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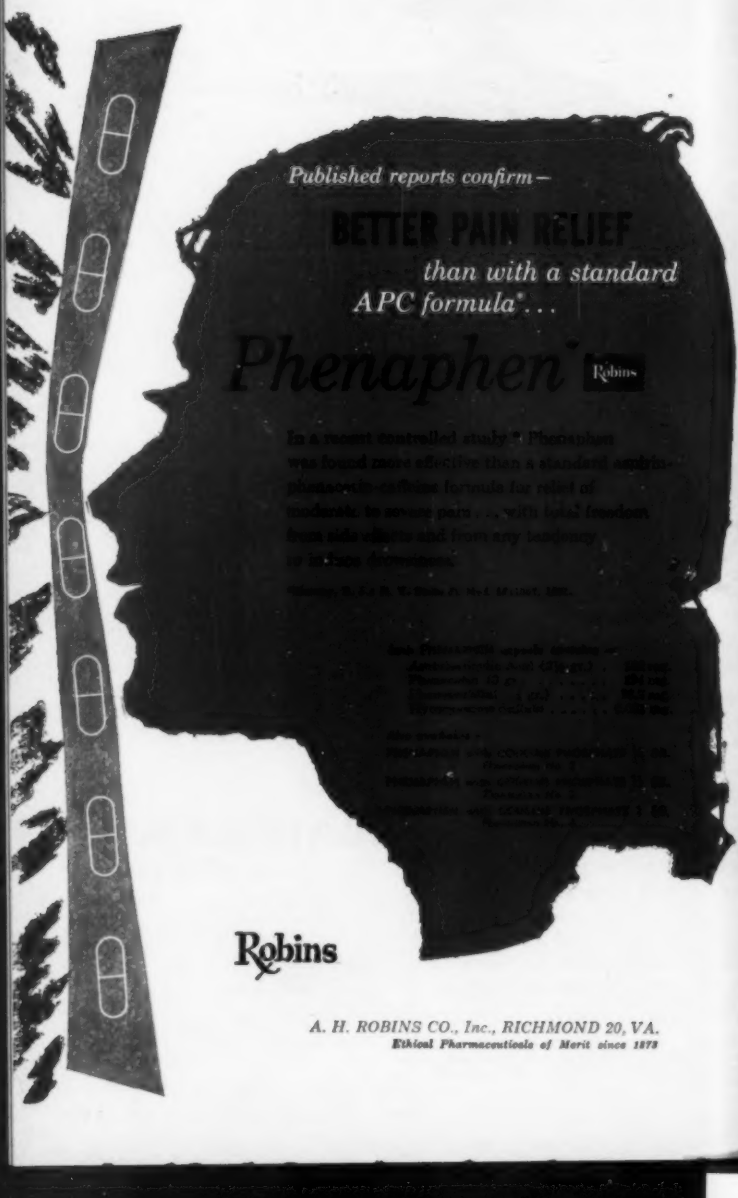
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churchyard and the townsfolk peered from their windows, they talked with every member of the medical staff, with several of the trustees, and with the administrator.

When they'd finished, the Council doctors themselves were in disagreement. As Dr. Albert C. Johnston, chairman of the Council, soon reported:

"There is a difference of opinion among the councilors as to who is at fault in the North Conway hospital dispute. Some say the physicians are being arbitrary, and an equal number say the trustees are encroaching on matters that are strictly the prerogatives of the medical staff. I believe there is some fault on both sides."

As it turned out, Dr. Johnston's middle view prevailed. The Council rebuked the trustees for interfering "in problems of a professional nature."

And it urged the doctors to "be considerate and cooperative with the trustees and try to reach an amicable agreement." What's more, it made the following specific recommendations:

Let the post of chief of staff be abolished. In its place, let there be elected staff officers, plus the committees required by Joint Commission rules. And let

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Average Adult Dose: 1 tablet q.i.d.

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the staff be divided into three groups—medical, surgical, and obstetrical—each with its own committee and elected chairman. (It said the staff was too small to be divided into five parts.)

Impartial arbitration—backed, as it was, by the power of organized medicine—cleared the air. As soon as the Council's report was received, the North Conway doctors got to work. Within three weeks, they had revised their by-laws and reorganized the staff in line with the Council's suggestions. And while they were doing the job, the trustees kept hands off.

Fruits of Their Labor

Immediately, hospital morale and efficiency began to soar. In July, an inspector from the Joint Commission visited North Conway and complimented the hospital's doctors on their reorganization and records. Two months later, Memorial was granted full accreditation.

Today, its patient load and its financial position are the best in its history. Its medical staff has three new associate members. Its accreditation has recently been renewed.

What lessons have the North Conway doctors learned that might be applicable to similar squabbles elsewhere?

First, they've learned how easily dissension can spring up and grow. Every time the trustees put pressure on the doctors, the doctors resisted. The more they resisted, the more the trustees pressed them. As Dr. Dore observes: "The dispute got blown up far out of proportion to the issues that originated it."

They Didn't Give Up

Second, they've learned it's important to keep talking, no matter how seemingly hostile the atmosphere. Several staff members credit their liaison committee with having prevented a far more serious rupture. Says Dr. Charles E. Smith: "The liaison committee bore the weight of the dispute. At least, they kept trying even when it seemed hopeless."

Finally, the disputants have learned how helpful outsiders can be. Although the idea of employing outsiders had been broached earlier, there'd been plenty of opposition to it. One trustee is said to have grumbled: "Do you think I'm going to let


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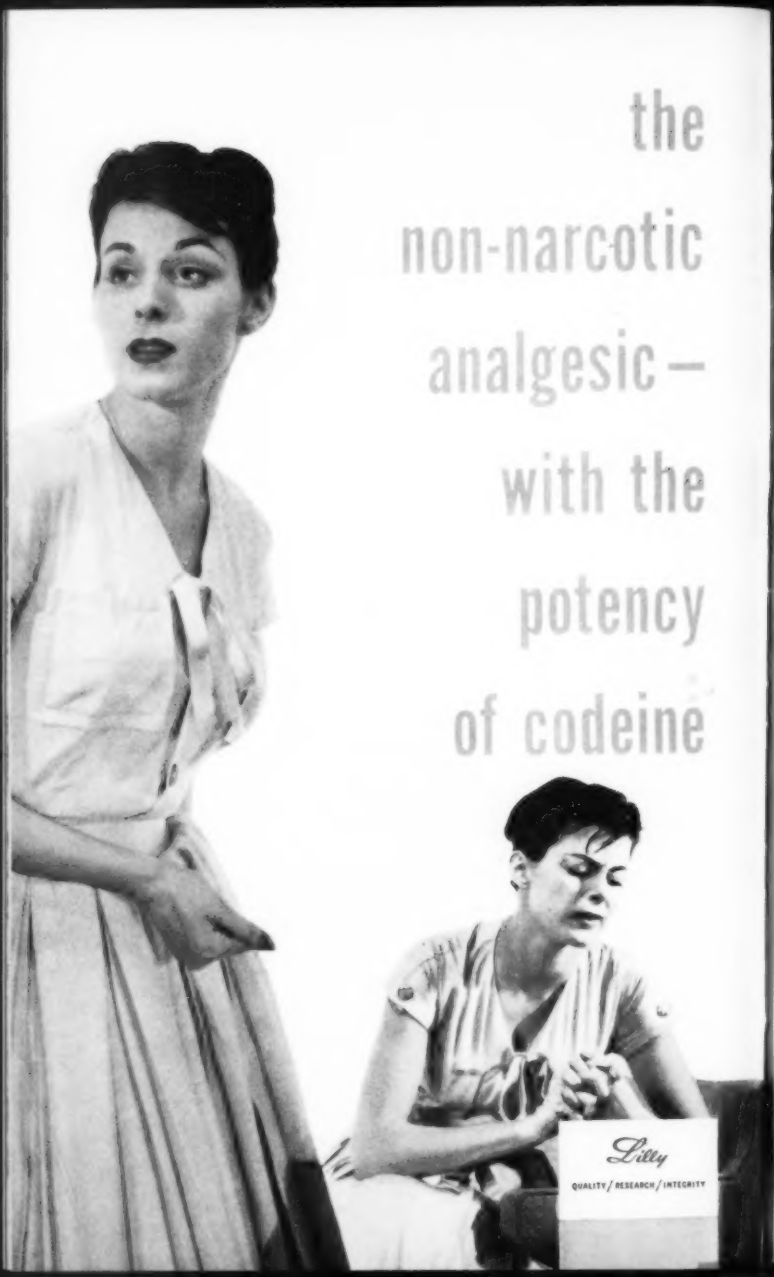
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'Darvon'	*32 mg.*
Acetophenetidin	*162 mg.*
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Dosage: *'Darvon Compound'—1 or 2 pulvules every six hours as needed for pain.*
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1. Gruber, C. M., Jr.: J. A. M. A., *164*:966 (June 29), 1957.

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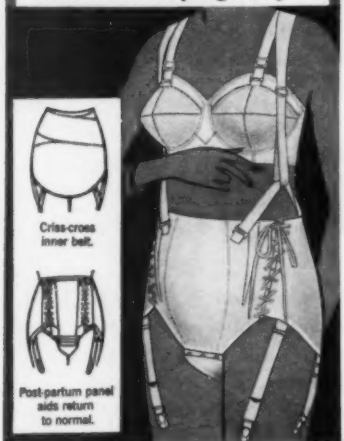

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the people in this town believe we can't settle this fracas by ourselves?" But there's general agreement today that if the non-local doctors had been called in earlier, some stormy and very unpleasant conflicts would have been avoided.

They Set a Precedent

That last lesson hasn't been lost on other New Hampshire hospitals. Note this commentary from Hamilton S. Putnam, executive secretary of the state medical society:

"When the Council went to North Conway, it was the first time in this generation that it had intervened in a dispute of such major proportions. Since then, several other small hospitals seeking accreditation have either copied the recommendations the Council made to North Conway, or else they have asked the Council to investigate their own situations.

'Establishes a Pattern'

"Most of the hospitals have obtained accreditation. Those that haven't are better off than they were before. The work of the Council in North Conway has established a definite pattern for the solution of such disputes." END

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House Calls: How Far? How Long?

By William N. Jeffers

What's the farthest distance you ordinarily go on a house call?

If you're typical of the urban and suburban respondents to MEDICAL ECONOMICS' house-call survey of some 1,200 practicing physicians, you go as far as eight miles from your office or home. But in a great metropolitan area— St. Louis, say, or Seattle—the typical house-call radius is ten miles. And in a *rural* district, it's fifteen miles.

Of course, you and your colleagues sometimes make calls that take you considerably beyond such normal orbits. What are your usual reasons for so doing? From the survey, the most common reasons for going far afield appear to be the following three:

1. To see a patient who has moved. (Says an Ohio,

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otent 'Trinsicon' offers complete and onvenient anemia therapy plus max- num absorption and tolerance. Just wo Pulvules 'Trinsicon' daily pro- uce a standard response in the aver- e uncomplicated case of pernicious nemia (and related megaloblastic nemias) and provide at least an aver- age dose of iron for hypochromic anemias, including nutritional deficiency types. The intrinsic factor in the 'Trinsicon' formula enhances (never inhibits) vitamin B_{12} absorption.

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G.P.: "Not long ago, I drove to a town fifty miles away to see a bus driver who called me because I'd treated him before.")

2. To care for an old friend or relative. (A North Carolina internist recalls: "Once, for five days in a row, I made a ninety-mile round trip to treat a sick cousin.")

3. For consultation. ("I've consulted with a colleague at the patient's home seventy-five miles from my office," says a Montana internist.)

Some of these out-of-the-ordinary calls take the doctor into *really* strange territory. "What's the greatest distance you've ever traveled on a house call?" asked MEDICAL ECONOMICS' researchers. "And what were the circumstances?" The answers to those questions were eyeopeners.

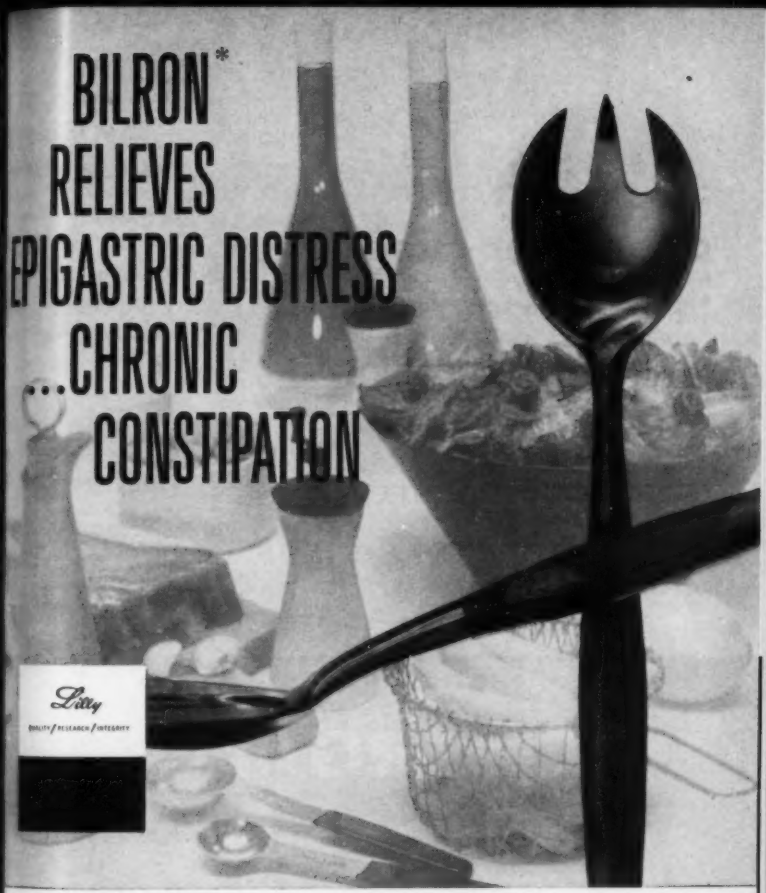
They Went Thataway

"The house visit that took me farthest afield entailed a 660-mile round trip," reports a G.P. in rural New Mexico. "It began with an emergency phone call from an elderly sheep rancher. He lived on an isolated ranch sixty-five miles out in the hill country. I bumped up there over dirt roads and found him in agony. After examining him, I decided that he had an acute suppurative appendicitis with perforation and peritonitis. I drove

Farthest Distance That Surveyed Doctors Ordinarily Go for House Calls

Area of Practice	1 to 5 Miles	6 to 10 Miles	11 to 15 Miles	Over 15 Miles
Metropolitan	28%	45%	15%	12%
Urban	37	33	14	16
Suburban	30	50	12	8
Rural	13	24	27	36

Distances indicated are one way only—not round trip. Median figure for metropolitan doctors: 10 miles. For urban and suburban doctors: 8 miles. For rural doctors: 15 miles.



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PHENERGAN brings quiescence to the patient. *Psychic sedative action* dispels fear apprehension and induces light sleep. *Antiemetic action* both curbs and controls her nausea and vomiting. *Potentiating action* permits reducing her dosage of analgesics and sedatives.

In Allergic Reactions:

PHENERGAN alleviates this patient's symptoms by its potent, prolonged *antihistaminic action*. It is effective in all allergic conditions responding to antihistamines — including this patient's allergic dermatosis. Other indications: hay fever, drug sensitivities, urticaria.

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him to the nearest hospital, about sixty-five miles farther on. There we found that the only surgeon was off at a medical convention. So we gave the patient supportive therapy, put him in an ambulance, and took him to another hospital—200 miles away over more country roads!

"He made a good recovery. So did I."

For an Austin, Tex., internist, one house call was considerably farther than that—a round trip of 1,660 miles. "To see a vacationing patient," he reports, "I was flown alone in a DC-3 with two pilots to Denver, Colo., a trip of about 780 miles. From there I was driven another fifty miles to Estes Park. I saw my patient there for twenty minutes. Then I returned to Austin the way I'd come. It could happen only to a Texan!"

He's wrong: A Long Island, N. Y., general practitioner reports he has at various times flown to California, Florida, San Salvador, and England to see well-to-do patients who "demanded service"—and got it.

Not so far as the above treks, yet perhaps more dramatic, was the call requiring a 170-mile round trip by a G.P. who now practices in California. Back in the Twenties, when he was the first pediatrician to practice in Arizona, "a mine foreman's child had been ill for nine days," he recalls. "She'd already been seen by three doctors—none of whom had undressed her. When I arrived, after an eighty-five-mile drive, I stripped the child at once. Buried in a buttock below skin level was a three-inch centipede! I excised it, and the child made a complete recovery. The father paid me $200 for my trip."

Charity Case?

A Utah doctor was less fortunate when, at 11 one night, he toiled off to see a pregnant woman 117 miles away. "Turned out she only wanted to know whether she was due that month or next," he says. "It was the next month. And I never did get paid."

Then there's the California G.P. who made a 200-mile round trip into the mountains to give transfusions with a syringe in a hemorrhage case. And the Floridian who trekked 124 miles into the hills and back—"car to jeep to mule"—to deliver a baby. And the Southwesterner

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whose explanation of why he once had to make a 120-mile round trip is simply: "It seems that one Indian shot another Indian."

Another laconic response comes from a South Dakota man. His terse explanation of why one call took him three days: "Blizzard."

The Time Calls Take

How much time does the *typical* doctor spend on the average call? About forty-five minutes, including travel time both ways, according to the survey findings. And, surprisingly, the figure's the same for typical house calls in all four categories: metropolitan, urban, suburban, and rural.

Why such unanimity? You'd expect rural doctors, who say they go farthest in making ordinary calls, to spend the most time making them. Probable answer: The open roads and open parking spaces of rural areas permit the country medical man to get where he's going without the long delays imposed by city traffic. (Such delays may be the reason why an unexpectedly high percentage of metropolitan doctors—21 per cent—report they regularly spend over an hour on a house call.)

When the doctor spends more

Length of Time That Surveyed Doctors Ordinarily Take for House Calls

Area of Practice	10 to 30 Minutes	31 to 60 Minutes	Over 1 Hour
Metropolitan	16%	63%	21%
Urban	27	66	7
Suburban	23	68	9
Rural	31	63	6

Times indicated include travel time coming and going. Median figure for doctors in all four areas of practice: 45 minutes.

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Children's Dosage: According to weight.

Packaging: 0.5 Gm., quarter-scored tablets, bottles of 24 and 100.

See literature for details of dosage and administration.

References: (1) Jackson, G. G., & Grieble, H. G.: *Ann. New York Acad. Sc.* 69:493, 1957. (2) Jones, W. E., & Finland, M.: *Ibid.* 69:473, 1957. (3) Lepper, M. H.; Simon, A. J., & Marienfeld, C. J.: *Ibid.* 69:485, 1957. (4) Ross, S.; Ahrens, W. E., & Zaremba, E. A.: *Ibid.* 69:501, 1957. (5) Walker, W. F., & Hamburger, M.: *Ibid.* 69:509, 1957.

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time than usual on a call, what's the likely reason? The survey suggests that the following three kinds of cases are more than ordinarily time-consuming:

Why They Miss Meals

1. *Home delivery.* (Says a surgeon of urban Minnesota: "I once spent almost six hours on a home-delivery case. It was an emergency call, but I had no details—my wife had taken the message. I went thirty-two miles out in the country and found a primipara about to deliver. There was no hospital within fifty miles and no ambulance service. Ten minutes after my arrival, the patient went into a uremic convulsion. The husband, who was the only other person present, became so frightened he ran off to the barn—and didn't return for five hours. The patient had four convulsions before I could apply forceps and deliver the baby. Then she had eight more attacks at ten- to fifteen-minute intervals. Both baby and mother survived.")

2. *Neurotic patients.* (Case in point from a Colorado pediatrician: "A neighbor of mine, the mother of four of my patients, phoned at 1 A.M. to announce she'd just poisoned herself and had left a note instructing that I be called to handle her remains. I didn't wait for the second call. It took me three hours to pump her out and get her on even keel again.")

3. *Cardiac cases.* ("Not too long ago, I was with one patient three and a half hours," says a Los Angeles G.P. "He had auricular fibrillation and cardiac decomposition. I couldn't move him to a hospital. I got emergency oxygen equipment and gave I.V. digitalis, aminophylline, morphine, and mercuhydrin. And I stayed there till he was resting easily.")

Heroes and Fall Guys

What's the most memorable of all these extra-length house calls? The true stories recounted by some of the surveyed doctors range from the dramatic to the droll.

Among the dramatic, listen to this nick-of-time thriller experienced by a Californian: "A ranger station called me for help. They said they suspected that a 3-year-old boy had fallen in the river at a certain mountain resort. They wanted me to come

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over and stand by. The place was twenty miles away, and I broke all speed laws getting there. As I rumbled over a small bridge near the resort, I saw a body floating in the water. I slammed on the brakes, climbed down on the bridge's underpinning, and grabbed the body just as it floated under the bridge. It was a little boy—the very one, I later learned, that I'd been called about."

The doctor gave artificial respiration for an hour and a half, and he finally got a response. The child was then taken to the nearest hospital, where he recovered. Total time spent on this call: four hours.

A thriller with a different conclusion is told by a Washington State doctor:

"A deputy sheriff was shot by an insane man. The sheriff picked me up at the hospital, and we drove an ambulance fifty miles to the scene of the shooting. When we arrived, another doctor met us and told us the deputy was already dead. I went off by myself to take a look at the body. When I came back, the doctor, the sheriff, *and* the ambulance had all disappeared. I thumbed a ride twenty miles to the nearest phone and got hold of the sheriff at his office in town. He said he was sure sorry to be so downright absent-minded. Eventually, he came out and took me back to my office. I'd spent ten useless minutes with the dead patient and eight hours coming and going."

Additional Duties

Even with a *live* patient, it's the side issues that often stretch a short call into a long one. Some examples:

¶ From an Ohio G.P.: "I was called at 7 A.M. to see a sick child. After I'd examined the patient, I was asked to examine the entire family, including Grandpa and Grandma. With travel time, the visit took me two hours and twenty minutes."

¶ From a Missouri internist: "I used to be especially interested in helping alcoholics. But I've had to quit. Such calls often require educating the whole family. Several times, I spent a full evening at the job."

¶ From a Colorado man: "A woman phoned at 8 P.M. and begged me to hasten over. I did; and there in the small living room were the woman, her husband, their four [MORE ON 232]

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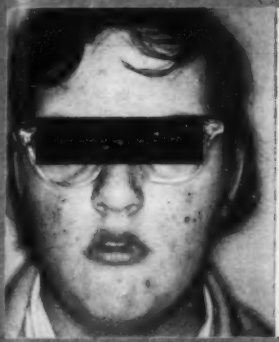

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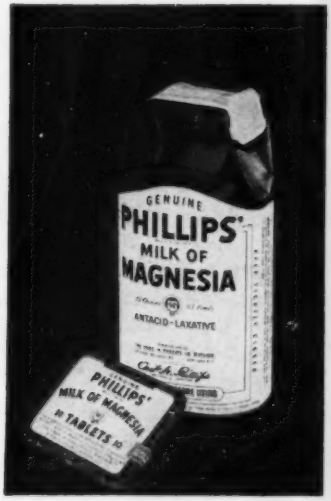

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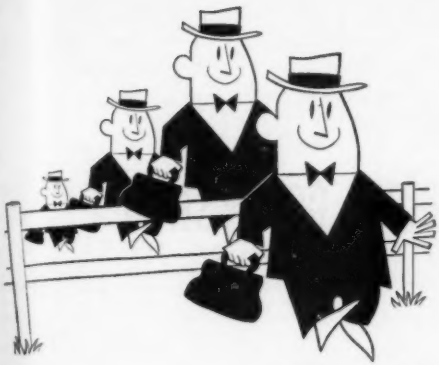


The Right Way To Produce More G.P.s

By Clifford F. Taylor

"How many doctors does this country really need? How many will it need in the years to come? And what kind of doctors should they be?"

When these three questions can be answered with *facts,* says Dr. Franklin Forsyth, dean at one of the country's best medical schools, the problem of overspecialization will solve itself. "There'll be no need for regulatory measures by medical schools, specialty boards, organized medicine, or the Government," he believes, "if new research is done *now*."

There's been a lot of talk lately about the mounting shortage of family doctors. Unless something is done to

---

THIS ARTICLE *reflects the current thinking of a good many medical school deans. Their spokesman (identified here as Dr. Franklin Forsyth) is the medical dean at a large Eastern university. His real name has been withheld so that he can say what he thinks without having to be polite.*

respiratory congestion orally

An orally administered decongestant has much better distribution to the mucous membranes of the respiratory tract than nasal sprays, drops and inhalants. "This affords opportunity for shrinkage in areas that could not be approached by sprays, drops or actual topical applications."

—MORRISON, L. F.: ARCH. OTOLARYNG. 59:49-53 (JAN.) 1954.

The Triaminic form and formulation, described in detail on the following pages, have proved remarkably effective as an oral decongestant.

STOP respiratory congestion orally

relief in minutes...lasts for hours

In the common cold, nasal allergies, sinusitis, and postnasal drip, one timed-release Triaminic tablet brings welcome relief of symptoms *in minutes.* Running noses stop running, clogged noses open—and *stay* open for 6 to 8 hours. The patient can breathe again.

With *topical* decongestants, "unfortunately, the period of decongestion is often followed by a phase of secondary reaction during which the congestion may be equal to, if not greater than, the original condition. . . ."[1] The patient then must reapply the medication and the vicious cycle is repeated resulting in local overtreatment, pathological changes in nasal mucosa, and frequently "nose drop addiction."

Triaminic does not cause secondary congestion, eliminates local overtreatment and consequent nasal pathology.

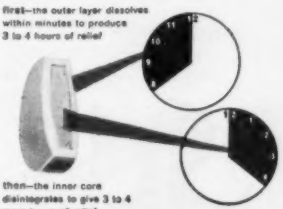
[1]Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

Each double-dose "timed-release" tablet contains:

Phenylpropanolamine hydrochloride . . . . . 50 mg.	for effective decongestant action
Pyrilamine maleate . . 25 mg.	two antihistamines to combat allergic symptoms without drowsiness
Pheniramine maleate . 25 mg.	

Dosage: 1 tablet in the morning, afternoon, and in the evening if needed.

Each double-dose "timed-release" tablet keeps nasal passages clear for 6 to 8 hours—provides "around-the-clock" freedom from congestion on just three tablets a day



Also available: Triaminic Syrup, for children and those adults who prefer a liquid medication.

Triaminic® "timed-release" tablets

STOP *running noses* *and open stuffed noses orally*

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

STOP respiratory congestion orally

plus control of cough spasm

- decongestant
- expectorant
- anti-allergic

Triaminicol is more than a cough syrup. First, because it contains Triaminic, it decongests nasal passages, and exerts its action on all mucous membranes of the respiratory tract—working at the *source* of cough. Then, Triaminicol provides Dormethan, non-narcotic antitussive that acts directly on the cough reflex.

Fully as effective as codeine, Dormethan is less likely to produce drowsiness or nausea. Its classic expectorant component, ammonium chloride, is well known for its ability to liquefy mucus and aid in the expulsion of exudates from the lungs and trachea.

Each 5 ml. teaspoonful provides:

Phenylpropanolamine hydrochloride	12.5 mg.
Pyrilamine maleate	6.25 mg.
Pheniramine maleate	6.25 mg.
Dormethan*	10.0 mg.
Ammonium chloride	90.0 mg.

in a delicious, fruit-flavored, non-alcoholic vehicle.

**brand of dextromethorphan hydrobromide*

Dosage: Adults—2 teaspoonfuls 3 or 4 times daily.
Children 6 to 12 years—1 teaspoonful 3 or 4 times daily.
Under 6 years—dosage in proportion.

NEW **Triaminicol** syrup

Non-narcotic antitussive

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STOP coughing for 6 to 8 hours

with one "timed-release" tablet

Tussaminic is non-narcotic—the patient simply swallows one timed-release "double-dose" tablet before breakfast to work cough-free all day. Another tablet before dinner lets him relax cough-free all evening. A final tablet at bedtime lets him sleep cough-free all night. Thus, cough relief is measured in hours, not minutes.

Tussaminic is not only valuable for the patient with a coughing cold, but also for the habitual morning hacker. And due to its Triaminic component, associated bronchial and nasal congestion frequently clears.

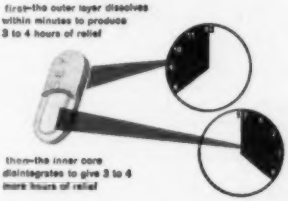
Each "double-dose" tablet contains:

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.
Dormethan*	20 mg.
Terpin hydrate	300 mg.

**brand of dextromethorphan hydrobromide*

Dosage: 1 Tussaminic tablet before breakfast, dinner and at bedtime.

Tussaminic "timed-release" tablets provide prolonged cough relief. Each tablet contains two full doses of long-lasting antitussive, expectorant, anti-allergic and decongestant components.



NEW Tussaminic "timed-release" tablets

Non-narcotic antitussive decongestant

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

XUM

STOP respiratory congestion orally

plus control of pain and fever

Congestion and associated discomforts of the common cold can now be treated *orally* with a single preparation — Triaminicin. Containing effective amounts of Triaminic for rapid clearing of the bronchial and nasal passages, Triaminicin also provides aspirin, phenacetin and caffeine to control headaches and fever. Triaminicin Tablets are buffered.

In addition, Triaminicin contains vitamin C to help raise resistance[1,2,3] to wintertime respiratory conditions.

1. Macleod, G., and Sherman, H. C., in Handbook of Nutrition, ed. 2, New York, The Blakiston Company, 1951, p. 284.
2. Brody, H. D.: J. Am. Dietet. A. 29:588, 1953.
3. Frazo, W. L., and Heyl, H. L.: J.A.M.A. 162:1224, 1956.

Each buffered Triaminicin Tablet contains:

Phenylpropanolamine hydrochloride	25 mg.
Pyrilamine maleate	12.5 mg.
Pheniramine maleate	12.5 mg.
Aspirin (3½ gr.)	225 mg.
Phenacetin (2¼ gr.)	150 mg.
Caffeine (½ gr.)	30 mg.
Ascorbic acid	50 mg.
Aluminum hydroxide (dried gel)	180 mg.

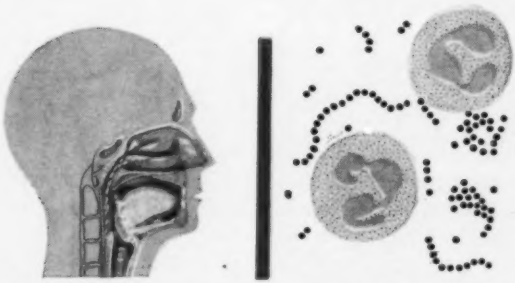
Dosage: 1 tablet every 3 to 4 hours.

NEW Triaminicin tablets

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

STOP respiratory congestion orally

plus control of bacterial invaders



With one unique preparation, you can now provide dramatic relief from respiratory congestion, and at the same time protect the patient from secondary bacterial infection. Through the action of Triaminic, its oral decongestant component, nasal patency is often effected within minutes of the first dose; breathing is easy again.

When bacterial invasion threatens, Trisulfaminic offers the wide-spectrum protection of triple sulfas. It is particularly valuable for the "almost well" patient recovering from endemic or epidemic influenza, and the patient prone to "lingering" or recurrent colds. And in purulent rhinitis, sinusitis and tonsillitis, Trisulfaminic offers a more realistic approach to the total treatment of the patient.

Each tablet or 5 ml. tsp. contains:

Triaminic . . . . . 25 mg.
(Phenylpropanolamine hydrochloride 12.5 mg., Pyrilamine maleate 6.25 mg., Pheniramine maleate 6.25 mg.)
Trisulfapyrimidines U.S.P.....0.5 Gm.

Dosage: Adults—2 to 4 tablets* initially, followed by 2 tablets every 4 to 6 hours until the patient has been afebrile for 3 days.

Children—6 to 12 years— 2 tablets initially followed by 1 tablet every 6 hours. Younger children in proportion.

**Each 5 ml. tsp. of Suspension equals 1 tablet.*

NEW Trisulfaminic tablets and suspension

TRIAMINIC® WITH TRIPLE SULFAS

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

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check the trend toward specialization, the nation's medical services will be thrown seriously out of balance, many authorities have said. Some of them have warned that we need controls *now* at the medical school level.

But Dr. Forsyth disagrees. "Let's get a really clear view of the situation before we start making brave new plans to meet it," he says.

Three-Point Program

One such plan was proposed last year by Dr. Dominick F. Maurillo, chairman of the New York State Board of Regents' license committee for professional education.* His suggested program for channeling fewer young doctors into the specialties and more into general practice included three main points:

1. Put specialization under the absolute control of the medical schools. Their faculties would then permit only the best-qualified students to train for special fields of practice.

2. Abolish the specialty-board system. (The boards, said Dr. Maurillo, have failed to limit the number of specialists.)

3. Speed up medical education in order to turn out more G.P.s faster. (And, Dr Maurillo added, it would be well to let them start practice right after graduation.)

You might think the dean of one of the country's great medical schools would welcome the authority such a program would give him. But Dr. Forsyth wants none of it.

"I don't think we should be given that kind of responsibility," he comments. "Our job is to offer the best possible training to our students. It's not to control the production of doctors."

In addition, he points out that the proposed plan would tend to push "left-over" students into general practice. "Would we be doing the nation a service by giving it *inferior* family doctors?" he asks.

As for abolishing the specialty boards, Dr. Forsyth says: "Like them or not, the boards are here to stay. Their primary function is to make sure specialists are properly qualified—and *not* to limit the output of specialists."

And he turns thumbs down, too, on the speed-up proposal: "If anything, G. P.s need *more* training, not less. The family doctor must be as fine an all-

*See " 'It's Time to Abolish the Specialty Boards!' " MEDICAL ECONOMICS, August, 1957.

anginaphobia: *air travel*

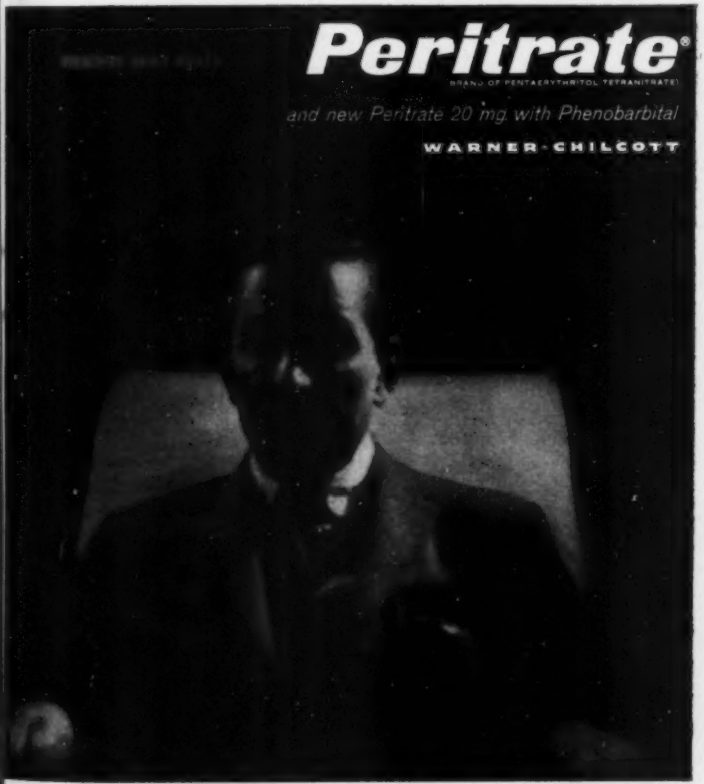
Fear of anginal attack has cancelled many a flight reservation. But anoxia at high altitudes need no longer be feared – thanks to pressurized cabins and modern management of angina pectoris. Actually air travel may even be preferable since it obviates otherwise long, tiring trips.

Peritrate removes the fear factor: A modern, long-acting coronary vasodilator, Peritrate, eliminates fear by helping eliminate attacks. And even though all customary restrictions cannot be abandoned, 4 out of 5 patients respond to routine use of Peritrate with

- fewer, milder attacks
- increased exercise tolerance
- reduced nitroglycerin dependence.

For the unduly apprehensive, for the overactive, for all who need mild sedation (especially early in treatment), Peritrate with Phenobarbital releases tension without daytime drowsiness.

Usual Dosage: 20 mg. of Peritrate before meals and at bedtime.



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around physician as we can turn out. If all you have to worry about is one part of the body, you can do a good job even though you're the slow and plodding type. But the G.P. needs to be exceptionally quick-thinking and versatile. We aren't going to produce such men on a fast assembly line."

Still, recent surveys show that roughly three out of four senior medical students intend to specialize. And the total number includes many who originally intended to become G.P.s. So how *can* students be won over to general practice without some such controls as have been suggested?

One answer, says Dr. Forsyth, is to redefine the traditional role of the family doctor. MORE▶

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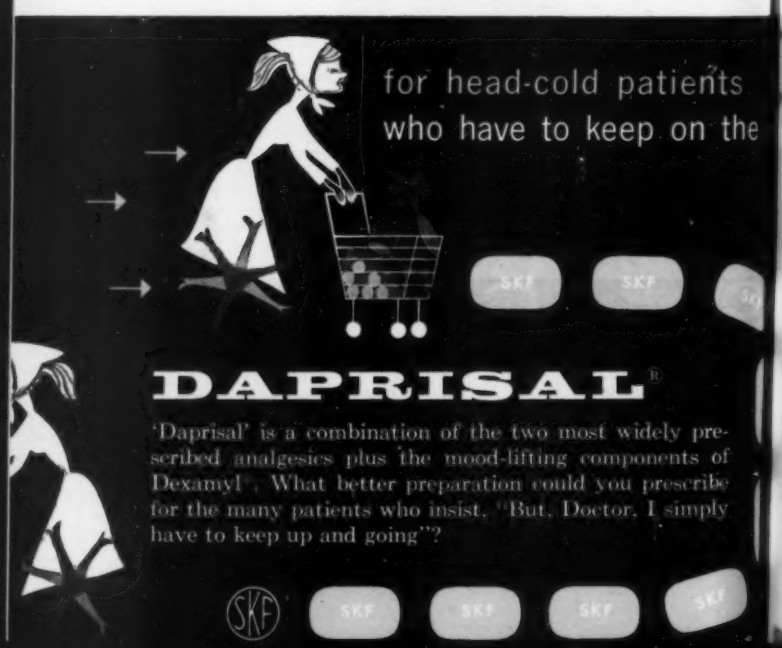
THE RIGHT WAY TO GET MORE G.P.s

"Of course medical students change their minds about becoming G.P.s," he explains. "During their training they learn how complicated and difficult medicine really is. Most seniors balk at the prospect of going out and treating everything that comes along. General practice, as we think of it today, is an almost impossible assignment for a conscientious doctor.

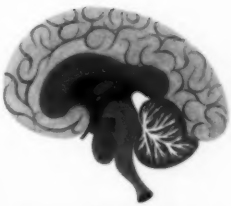
"I agree with those who see tomorrow's family physician as mainly an internist with pediatric training. He'll also have some knowledge of psychiatry. But he won't attempt anything beyond minor surgery. And he may—if he plans on a small-town practice—have training in obstetrics."

The chief job of this internist-pediatrician-psychiatrist, as the dean sees it, will be to provide medical care for the entire family. "And that means for its infants too," adds Dr. Forsyth bluntly: "Most pediatricians I know are bored to death. There aren't enough seriously sick children to make their practice interesting. I believe that tomorrow's family doctor will take



relaxes both mind & muscle

without impairing mental or physical efficiency



well tolerated, relatively nontoxic / no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness / well suited for prolonged therapy

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets. *Usual dosage:* One or two 400 mg. tablets t.i.d.

For anxiety, tension and muscle spasm in everyday practice.

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'Miltown' therapy resulted in complete relief from symptoms in 88% of pregnant women complaining of insomnia, anxiety, and emotional upsets.*

'Miltown' (usual dosage: 400 mg. q.i.d.) *relaxes both mind and muscle* and alleviates somatic symptoms of anxiety, tension, and fear.

'Miltown' therapy does not affect the autonomic nervous system and *can be used with safety throughout pregnancy.**

*Belafsky, H. A., Breslow, S. and Shangold, J. E.: Meprobamate in pregnancy. Obst. & Gynec. 9:703, June 1957.

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over routine child care. We'll then need comparatively few highly trained pediatricians—for referred work only."

He concedes it will take a while for this new family-doctor concept to evolve. "But when the evolution has taken place," he says, "it will make general practice far more attractive to the medical student. And meanwhile there's one constructive step we could take to help solve the problem of doctor distribution: Try to find what the medical needs of the American people really are.

"By *needs*, I don't mean *demands*. Americans demand more automobiles than they actually need. It's possible they tend to do the same with medical care."

What Dr. Forsyth suggests is a gigantic research project—"a market-analysis type of study on a representative cross-section of the population. We ought actually to diagnose them. If the study were done on a large enough scale, it would show whether or not the people are getting the medical services they actually need. If they're not, it would indicate what services *are* needed."

Who should sponsor such a study? "It's the responsibility of organized medicine," says Dr. Forsyth. "It would be a big job. But we doctors could do it. And

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Small concentrated dosage
1.5 cc. child size
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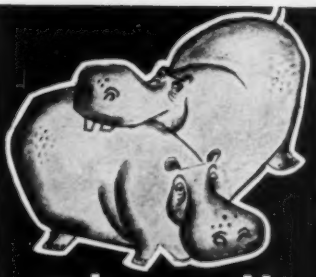

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doubles the power to resist food in obesity
• curbs the appetite
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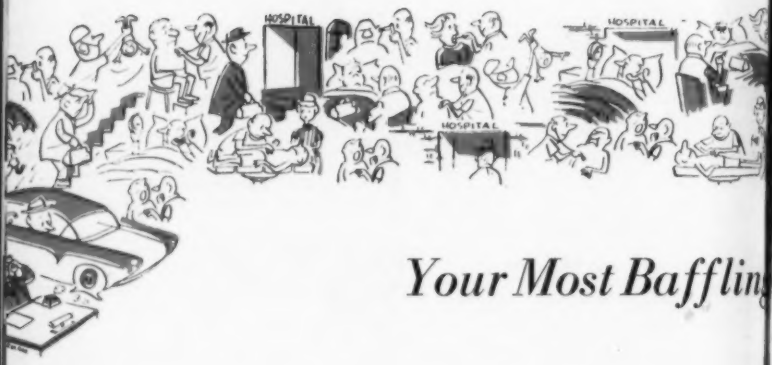
we *should*—because if the country's real needs were known, it would do more than anything else to help physicians choose the right fields of practice."

Medical students, he concludes, would be quick to grasp the implications of the kind of

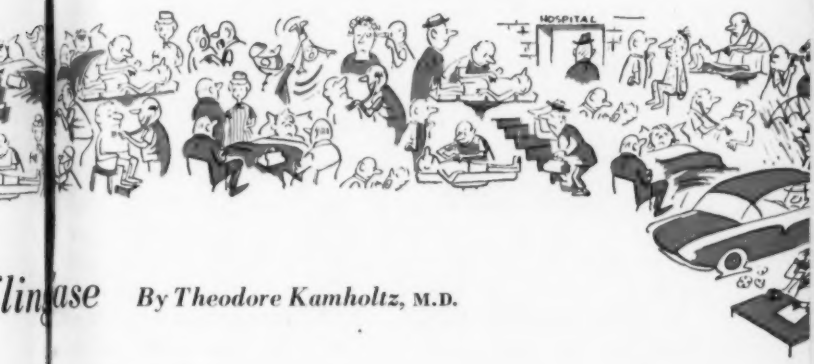


Your Most Baffling Case

Tried treating your wife lately? It can be be pretty trying. In fact, if your experiences are like mine, it's likely to involve you in the most baffling case of your career.

Your first inkling that something is wrong comes the night you get home an hour late for dinner, just fifteen minutes before evening office hours. You're racing through your meal and juggling a four-way conversation with your wife and kids while speculating on the nature of the messages on the telephone pad. You've finished your soup, decided you should visit Mrs. Dunwoody tomorrow, and commiserated with your children on the irritations of school life. You still have five whole minutes in which to finish eating, complain about the car, and inquire into your wife's day.

study he recommends. "These boys aren't stupid," he says. "Once they had actual facts to go on—instead of plugs from interested parties—they'd know where they're needed. And they'd know that where there's need there's *opportunity*." END



lin ase

By Theodore Kamholtz, M.D.

Then it happens. Your wife points to an area on the dorsum of the middle phalanx of the little finger, left hand. It aches, she says. Sometimes it gets a little red and swollen. Sometimes it throbs. At other times, it feels perfectly all right, except it's not quite so strong as usual. Occasionally there's a pressure sensation in the palm . . .

You listen carefully for two minutes, then drift into wondering whether you can possibly see Mrs. Dunwoody tomorrow after all. Finally, you grunt noncommittally and go to the office.

The next day after lunch, your wife repeats the symptom complex with a few embellishments. On examining the finger, you find nothing abnormal. So, with a mental note that you really must cut down on your evening work

and take your wife out more often, you reassure her that there's nothing to worry about.

"Just rub a little oil of wintergreen on it," you say. "And keep it out of water for a day."

When you get into your car after breakfast the next morning, you remember to shout an inquiry about the finger. But you can't make out the answer above the noise of the motor.

Two days later, your wife arrives at your office with her hand in a sling. For the first time, you're startled. You give her your ten-dollar special, usually reserved for the alderman and the president of the women's auxiliary.

You do a thorough physical, followed by a complete neurological exam. You inspect the little finger with the lens. You see nothing but a very slight reddening. So you take a radiograph. It shows nothing.

Still Nothing Wrong?

You wind up by telling the little woman in your most professional manner that you can find nothing wrong—and you show her the X-ray to back up your verdict.

Next morning, your wife staggers to the breakfast table, an ice bag on her head, dark circles under her eyes. Anxiously, you ask what's the matter and shudder as she answers, "The pain in the finger is worse."

She's been up all night. She has a backache with drawing sensations in the flanks. And, for the past three hours, she's had a pulsating tenderness over the right temporal region. No, she hasn't any fever, but she has periodic nausea.

Consultant's Opinion

You send her to bed and take your youngsters to school yourself. You rescue the X-ray from the waste basket where you'd filed it and take it to a radiologist friend. He agrees with you that it shows nothing. But he qualifies his opinion with: "Of course, this doesn't rule out the possibility of an early osteomyelitis."

That night, you lie awake reviewing the problem from all possible angles. Could this really be osteomyelitis? What about that small red area on the finger you'd thought insignificant? What about the right temporal headache? Was it a small embolus? And the drawing flank pain—a renal infarct? MORE

the chill

the cough

the aching muscles

the fever

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SUPPLIED: Capsules, bottles of 36. Each capsule contains 62.5 mg. (100,000 units) of penicillin V, 194 mg. of salicylamide, 6.25 mg. of promethazine hydrochloride, 130 mg. of phenacetin, and 3 mg. of mephentermine sulfate.

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MOST BAFFLING CASE

You're filled with choking sensations. You're full of love, apologies, and regrets.

It's a long night.

Next morning, you dress your children and hush them through their routine. Very tenderly, after the youngsters are at school, you take your wife to your office. You do a chest plate, urinalysis, and sedimentation rate. You take a blood count, BMR, and ECG.

You present these findings to your colleagues.

You Never Know

The internist doesn't think them significant, but he remembers one of his early cases—poor woman. He had diagnosed neurasthenia. As it turned out, she had . . . But, then, your wife's case isn't too similar . . .

You hurry to the neurologist. He pats you on the shoulder and suggests you bring your wife to his office . . .

You move on to the orthopedist, who shrugs and says there's nothing definite—yet . . .

Meanwhile, you cancel your hospital appointments and every office call that's not absolutely vital. You stay home, changing ice bags and massaging your wife's back. A hush has fallen on the house. You spend much

when are tranquilizers indicated in pediatrics ?

ATARAX
in any
hyperemotive state

for childhood behavior disorders
10 mg. tablets—3-6 years, one tablet t.i.d.; over 6 years, two tablets t.i.d. Syrup—3-6 years, one tsp. t.i.d.; over 6 years, two tsp. t.i.d.

for adult tension and anxiety
25 mg. tablets—one tablet q.i.d. Syrup—one tbsp. q.i.d.

for severe emotional disturbances
100 mg. tablets—one tablet t.i.d.

for adult psychiatric and emotional emergencies
Parenteral Solution—25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

Some doctors have questioned the use of tranquilizers in children. They feel, and rightly so, that these drugs should not be used as palliatives to mask distressing symptoms, while etiological factors go uncorrected. But there are three situations in which even the most conservative physician would not hesitate to use tranquilizers:

1. When the usually well-adjusted child needs a buffer against temporary emotional stress, such as hospitalization.
2. When a child needs relief from an anxiety-reaction that is in turn anxiety-provoking, so as to pave the way for basic therapy.
3. When anxiety underlies or complicates somatic disease, as in asthma.

In such situations, tranquilizers are likely to be more effective and better tolerated than previously accepted therapy, such as barbiturates.

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time reminiscing over your courtship and early married years. What little time you're away from home you spend in the medical library and with various specialists whose suggestions are painfully unspecific. Watch and wait, they say.

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It's dawn when you get home. You fall into bed and into a dead sleep. When you awake, you have difficulty reorienting yourself. Then you hear your wife talking to the kids and it all comes back.

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What Working Hours For Doctors' Aides?

The typical physician can hardly be called a slave-driver. He himself regularly puts in a sixty-hour week, according to MEDICAL ECONOMICS' 8th Quadrennial Survey. But a study recently completed by this magazine indicates that his office employes are required to work only the standard forty-hour week.

Some 600 physicians in private practice throughout the country were asked to answer a number of questions about the working hours of their full-time aides (those who put in at least thirty-five hours a week). Here are some of the major findings:

Fully two-thirds of the respondents' aides work forty hours or less—including up to five evening hours—in a regular week. The actual median (or most typical) workweek: a total of forty hours, including four hours after 6 P.M. These figures hold true whether the doctor has only one aide or several. Nor is there any apparent difference among the number of hours put in by nurses, technicians, bookkeepers, receptionists, etc.

Most medical assistants work no more than forty hours a week, this survey shows

By Arthur Owens

Even the type of practice seems to make little difference in a girl's total working hours. But her employer's specialty may affect the number of *evening* hours she puts in. For example:

The typical pediatrician's aide reportedly works only two hours a week after 6 P.M.; the typical psychiatrist's aide, only three. The internist's assistants, on the other hand, generally spend five evening hours in the office during a normal week.

As the accompanying table shows, there are plenty of exceptions to the forty-hour week. It seems significant, though, that only 3 per cent of the G.P.s and only 2 per cent of the specialists say their aides work more than *fifty* hours a week.

Still, the survey did turn up one woman—a 36-year-old Massachusetts R.N.—whose employer reports she works *eighty* hours a week, twenty-eight of them at night. Why such long hours? Partly because she's the only office assistant to an extremely busy general surgeon. And part-

XUM

ly because she also goes with him into the operating room every day to act as instrument nurse.

Her salary is $95 a week—nearly 50 per cent more than the national median for her job.* She also gets paid for her overtime at a higher hourly rate. And she receives an occasional bonus (the most recent of these was $100).

Twelve-Hour Day

Another girl who's worked hard by her employer is a North Carolina secretary. She puts in a weekly average of seventy-two hours. Her boss, an ENT man, says he pays her a straight 85 cents an hour—or $61 for her normal work-week. Last year he also gave her a $1,200 bonus. In effect, this brought her weekly earnings up to about $85. But it still left her *hourly* earnings 37 cents below the national median for medical secretaries ($1.55 per hour).

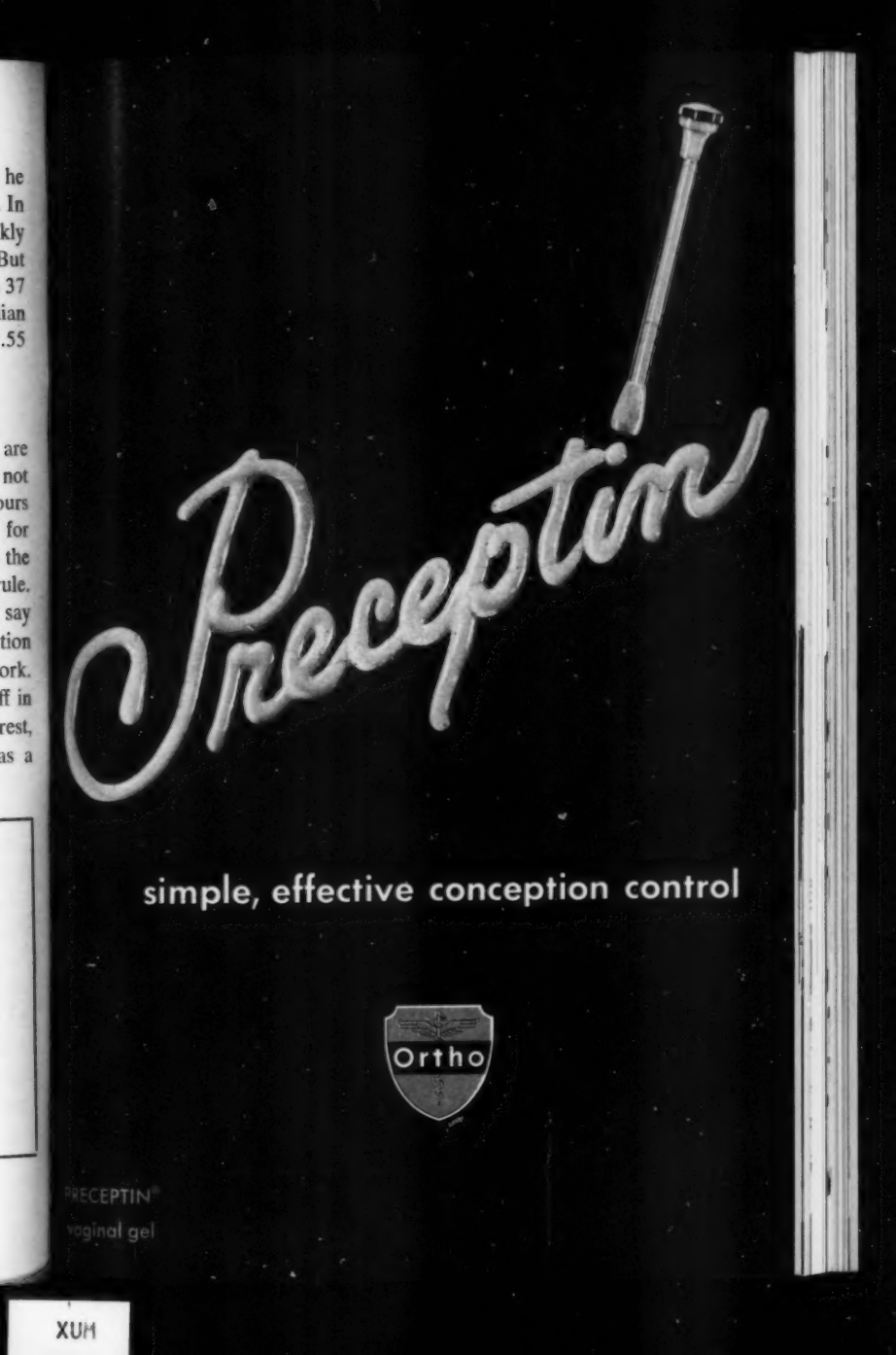
Overtime Pay

The two cases just cited are exceptional, of course—and not merely because of the long hours both aides work. Payment for overtime also appears to be the exception rather than the rule. About half the respondents say they give no extra compensation of any kind for overtime work. One-third give equal time off in lieu of additional pay. Of the rest, only about one in eight has a

*For more data on aides' salaries, see "How Much Do Doctors Pay Their Aides?," MEDICAL ECONOMICS, Jan. 6, 1958.

Regular Work-Week of Doctors' Full-Time Aides

Aides' Work-Week	Percentages of Aides Who Work These Hours in: G.P.s' Offices	Specialists' Offices
35-40 hours	60%	73%
41-45 hours	27	19
46-50 hours	10	6
Over 50 hours	3	2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definite policy of paying cash for extra hours worked—most commonly at the regular hourly rate.

Finally, what about absenteeism and tardiness? The surveyed physicians cope with these twin problems in a number of ways. Here are some examples of their techniques:

¶ Says a Kansas pediatrician who has two aides: "No work, no pay. And if a girl is constantly tardy, I give her a choice of mending her ways or getting another job. It works."

The Velvet Glove

¶ A neurological surgeon in Maryland has a gentler approach: "I duck the problem by paying my aide on a quarterly rather than an hourly basis. Then I let her set her own hours—just so she gets the work done."

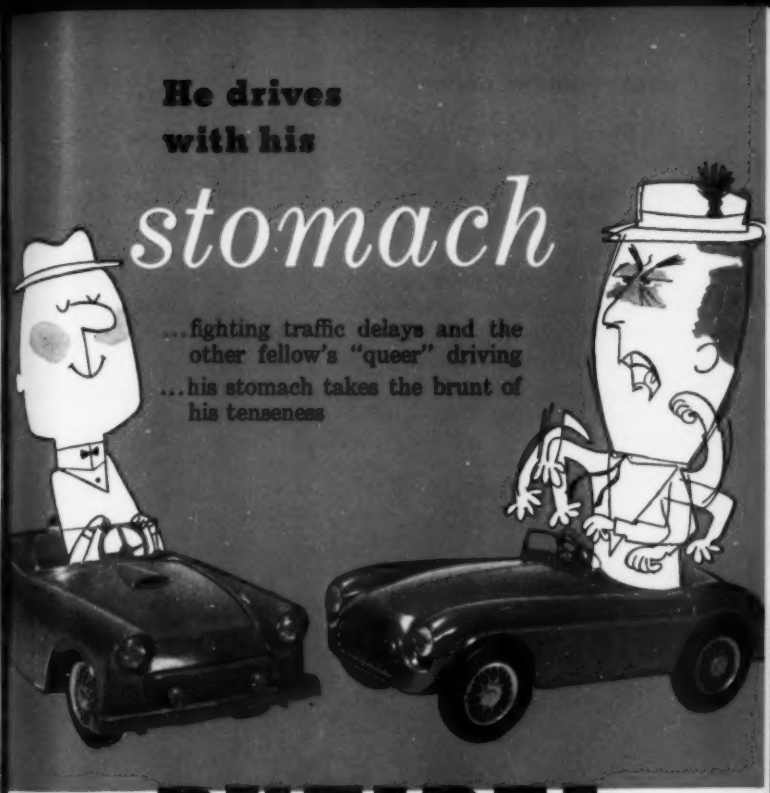
¶ "My girls are allowed twelve days of sick leave a year," reports an Iowa radiologist. "If they don't use it all by the end of the year, they can have a half-day of vacation for each day of sick leave that they haven't used."

Disability Insurance

¶ A California urologist has this to say: "My girls are interested and loyal enough not to take advantage of me. So I always pay them when they're sick. I've insured them against prolonged illness so as not to have to pay both an absent employe *and* her replacement." MORE ▶

How Doctors Compensate Their Aides For Overtime Work

47% give no compensation
34% give equal time off later
7% give extra pay at regular hourly rate
5% give extra pay at a different hourly rate
7% have no definite policy



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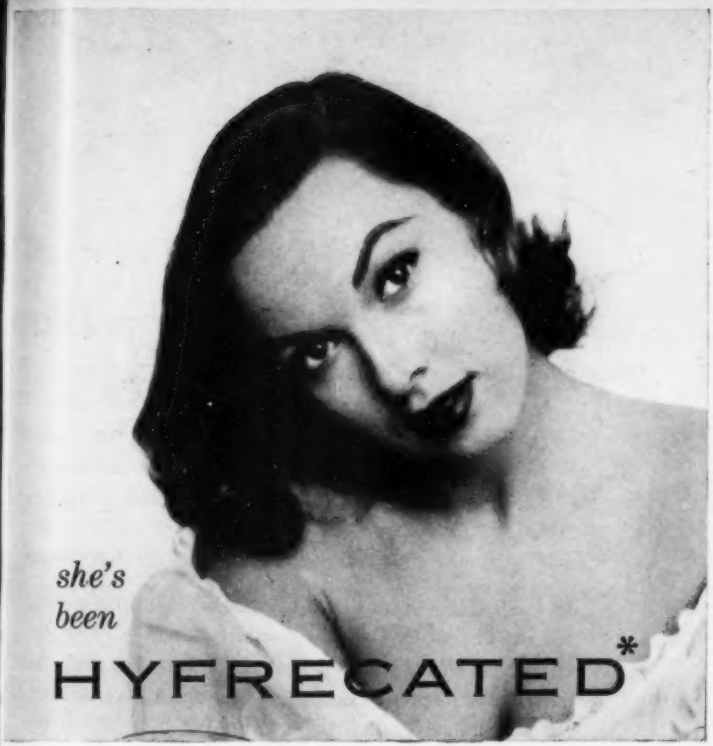
AIDES' WORKING HOURS

¶ Three Texas G.P.s who share an office and seven aides give their girls unlimited time off for sickness. But they make sure an absent employe *is* sick. Their policy: "Illness requiring time off from work also requires an examination by a physician of the aide's choice—usually one of the men in this office."

The bonus idea really seems to pay off as a means of discouraging unnecessary absenteeism and tardiness. More than half the respondents say they hold out the promise of periodic bonuses. The aide is seldom told in advance the exact amount of her next bonus—but she does know that it will depend, in part at least, on how dependable she herself has been. END

"She says the blood you took for the Wassermann cured her, so she's canceling her appointment."



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Why Blood Ba

Pro- and anti-Red Cross factions are making a fiasco of blood-coordination efforts. Here's what you should know about a growing conflict

By Wallace Croatman

In 1955, a new Joint Blood Council was set up under the sponsorship of five organizations: the A.M.A., the Red Cross, the American Association of Blood Banks, the American Hospital Association, and the American Society of Clinical Pathologists. Everyone hoped that the Council would mark the beginning of a new era in blood banking—that it would end a long-standing feud between the Red Cross and other blood-procurement agencies.

But the hope has proved false. Today, more than two years after the Council opened its executive office in Washington, D.C., bad feeling is, if anything, sharper than ever. And the nation's doctors can't duck the issue much longer.

This conclusion emerges from an intensive investiga-

THIS ARTICLE *is the second of a series on doctors' relations with community blood programs. The first, "What You Don't Know About Your Blood Bank," appeared in* MEDICAL ECONOMICS, *December, 1957.*

Banking Is Still a Mess

tion into current blood problems. For the past year, MEDICAL ECONOMICS has been collecting opinions from pertinent sources: men and women in all ranks of the blood-bank hierarchy, hospital representatives, clinical pathologists, A.M.A. spokesmen, and private medical men. The study reveals that every effort to set up a coordinated national blood program has so far failed.

Why? Why have the country's two big blood-banking organizations, the American National Red Cross and the American Association of Blood Banks, been unable to work together?

There seem to be several reasons for the continuing hostility. It crops up particularly in these four areas:

Areas of Conflict

1. *Attitudes toward the Joint Blood Council.* The Red Cross apparently regards the Council with paternal tolerance. It knows that the Council, as presently organized, isn't going to upset the status quo. And the Red Cross, as the only Government-recognized blood-procurement agency, appears to like the status quo.

On the other hand, the A.A.B.B. joined the Council

in the belief that the joint organization would eventually take over the functions of the Red Cross in dealing with the Government. Some outspoken members of the Association now want it to pull out of the Council unless the latter takes steps to unseat the Red Cross.

2. *Collection of blood for defense.* A year ago, the Red Cross agreed to collect 332,000 units of blood to be turned into serum albumin for civil defense. It asked A.A.B.B. centers to provide about 101,000 units of the total. Some sixty non-Red Cross banks expressed interest in joining the drive, and contracts were eventually signed with nineteen banks.

But the non-Red Cross banks have fallen far short of their original quotas. Why have they failed? The answer depends on whose story you listen to.

Carl F. Belliston, administrative director of the Red Cross Blood Program, blames the fact that some non-Red Cross centers have no donor-recruitment systems. Such banks, he says, evidently expect the Red Cross to do their recruiting for them.

For its part, the A.A.B.B. charges that the Red Cross short-circuited the Joint Blood Council when it made its agreement with the Government. And the Association argues that the original contracts were needlessly stringent in insisting on fresh whole blood when outdated blood or plasma would have done. (To this charge, the Red Cross replies that the whole-blood requirement came from the Government. In any event, the requirement was modified last May.)

Dr. Oscar B. Hunter Jr., A.A.B.B. president, describes the serum-albumin project as a "kind of boondoggle." Less moderate A.A.B.B. members have accused the Red Cross of trying to make other blood banks look bad.

Limited Cooperation

3. *Reciprocity—or the lack of it.* Each of the two organizations has its own national clearinghouse system, which permits the exchange of blood on a debit-and-credit basis. Thus, for example, a patient who gets blood in one city can have a friend or relative replace it in a city thousands of miles away.

Both the Red Cross and the A.A.B.B. clearinghouses are

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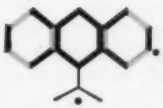

working well. In addition, informal reciprocity agreements have been reached between Red Cross and other banks in certain parts of the country. But, so far at least, efforts to establish a unified *national* reciprocity system simply haven't succeeded.

Name-Calling

4. *Local disputes.* In a classic example of ill feeling, Houston (Tex.) doctors and the Red Cross traded insults during the Korean War. The Red Cross was called "socialistic" by some physicians. In return, it accused the doctors of "profiteering" from their support of a non-Red Cross blood bank.

Recent disputes may have been less heated. But they're no less damaging. In New York State, for example, the doctor-sponsored Blood Banks Association still can't get much public support for a blood "assurance" program set up more than three years ago. One possible reason: The Red Cross has denounced the plan, implying that physicians and hospitals would reap a large profit from it.

Conversely, the Red Cross has

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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc. and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

had to abandon its New Orleans blood program because of opposition from hospital interests. And in Chicago, a bloc of commercial and hospital banks has long throttled suggestions that the Red Cross enter this area.

The Underlying Issues

It's easy to find areas where the Red Cross and the A.A.B.B. can't agree. But *why* can't they agree? Probably the key reason is that the Red Cross got into blood banking first—on a national basis, at any rate. It had a head start; and it apparently intends to maintain its lead over the late-comers.

In the following discussion of issues, you may not find clear-cut answers as to which side is *right*. But the facts as presented should help you sort out the claims and counter-claims if a conflict ever arises in your community.

POWER AND PRESTIGE: As far as the Government and a large part of the public are concerned, the Red Cross is the *only* blood-banking organization. This impression dates back to World War II, when that was actually the case.

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The roots of the present trouble go back to 1947, when the Red Cross officially went into civilian blood procurement. In the same year, a group of hospital, community, and commercial blood-bank leaders—many of them motivated chiefly by a desire to keep the Red Cross from getting a monopoly—formed the American Association of Blood Banks.

But in spite of the competition, the fifty-one Red Cross regional centers today draw more than 2,000,000 units of blood a year —about 40 per cent of all the blood transfused in this country. That's a lot more than the total collected by the 350 institutional members of the A.A.B.B.

One reason why the Association doesn't do better may be its lack of a strong organizational set-up. It's really just a loose collection of member-banks. Some of them are small, single-hospital banks. Others are profit-making ventures. Others are big community centers such as those in Milwaukee, San Francisco, and Seattle. And whereas the fifty-one Red Cross centers operate under a single National Institutes

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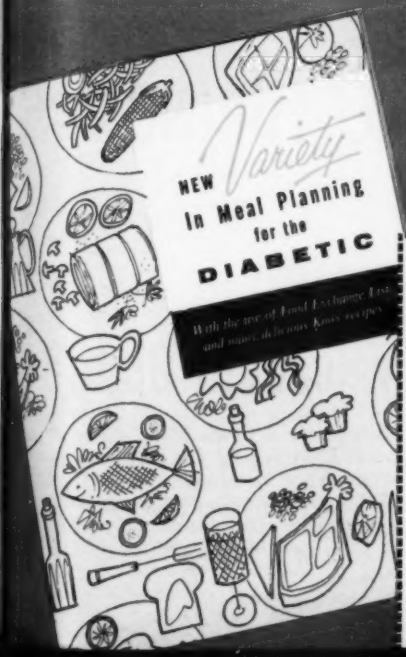
of Health license, only 100-odd of the 350 A.A.B.B. banks are licensed by the N.I.H.

Still, the Association has grown to a point where it feels it can begin to challenge Red Cross supremacy. As the next step in this direction, it is opening an office in Chicago for a full-time executive director.

DEPENDABILITY: The A.A.B.B. emphasizes that its sole interest is blood, whereas blood is only one of many Red Cross activities. This is a significant difference, since it's always possible that the Red Cross program may be expanded or curtailed for reasons that have nothing to do with its value.

A Wise Decision

After the Korean War, in fact, the Red Cross seriously considered curtailing or even eliminating its blood program. It decided not to do so, however. And it has since discovered one excellent reason why the decision was a wise one: A recent survey has shown that the organization's blood programs appear to be the best understood and appreciated of all its services. MORE▶



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Even so, there's no assurance that the Red Cross will retain its interest in blood procurement. Last spring, when the organization was going through an austerity wave, its blood program escaped drastic pruning. But another economy drive could force some curtailment of the program.

PUBLICITY: On the local level, both the Red Cross regional centers and the larger A.A.B.B. banks use all the basic public relations techniques. Both employ publicists who grind out news releases about Rh babies and leukemia victims, take writers and editors to lunch, solicit support from local industry, and stage all sorts of blood-raising stunts.

On the national level, though, the A.A.B.B. is practically unknown to the public. Whereas the Red Cross is—well, the Red Cross.

What They're Promoting

As Dr. Sam T. Gibson, director of its blood program, remarked a few months ago: "Sure, we're promoting the Red Cross. But when you promote the Red Cross, you're promoting the public interest."

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Only a very rash magazine or TV commentator would attack the Red Cross. After all, hasn't it been the "Greatest Mother of Them All" for more than seventy-five years? No doubt about it. The American people have been trained to assume that what's good for the Red Cross is good for the country. During the organization's fund-raising appeal each spring, for example, the public is deluged with publicity statements like these:

¶"The Red Cross is the heartbeat of America. It enables all of us to express the universal desire to help a less-fortunate neighbor wherever he may be . . . A family crushed by disaster needs aid to rebuild its tornado-smashed home...A doctor calls for blood to save a sick child's life . . ."

¶ "The story of an 84-year-old bedridden mother and her two widowed daughters in East Stroudsburg, Pa., could be that of many of the families aided by Red Cross in the Eastern floods: Their small, neat frame house and all it contained was wrecked by the raging waters . . . Red Cross gave them food, clothing, needed medical supplies . . . and

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a new completely furnished dwelling as an outright gift of the American people . . ."

How can the A.A.B.B. compete with *that?*

PROCESSING COSTS: In a recent issue of the Journal of the College of American Pathologists, Dr. Coye C. Mason estimated it costs a small hospital bank almost $10 a unit to collect and process blood. Larger blood centers do it for less—sometimes for as little as $6. Red Cross per-unit costs are especially low, thanks to extensive use of volunteers, large-volume purchase of supplies, and other factors. But under any system, as Dr. Mason points out, "It costs money to process blood."

Where does the money come from? Some non-Red Cross banks charge a straight service fee of perhaps $10 a unit. Some count on penalty fees forfeited by patients who fail to have blood replaced. Some banks wind up with a surplus of blood through replacement or "insurance" plans; then they simply sell that blood.

But the Red Cross sees it differently. Its original theory—since modified, as we'll see below—was that expenses should be borne entirely by Red Cross funds. (The Government, of course, has always paid most of the costs of blood collected for defense and the armed forces.) Much of the early bitterness between the Red Cross and the A.A.B.B. can be traced to the former's criticism of programs that charged service and/or replacement fees.

Says Dr. Gibson: "We have promised *our* donors that if they give us their blood, nobody will sell it or make a profit on it."

Nowadays the Red Cross shifts part of its blood-collection expenses to the hospitals that receive its blood. Here's how costs are distributed:

Red Cross national headquarters pays each regional blood center $1 for each unit drawn for civilian use. It also reimburses the center for blood collected for other purposes, such as use by the armed forces, disaster needs, and civil-defense stockpiling.

The regional center contributes at least $1 a unit toward actual collection expenses. It also pays for such fringe expenses as promotion of the blood program and canteen operation.

The rest of the cost is usually passed on to hospitals (and even-

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tually to patients) through what's euphemistically called a "hospital participation" charge. Typically, such charges come to about $3 a unit. But, as every A.A.B.B. member knows, the average layman is given little reason to question Red Cross philanthropy.

REPLACEMENT: Non-Red Cross banks generally require the patient to have blood replaced on a one-to-one, two-to-one, or even three-to-one ratio. If he can't do it, he forfeits a deposit of $25 or more. This system and similar ones are designed to give people a financial motive for donating blood.

Red Cross centers, on the other hand, have traditionally held that blood replacement is primarily a community—rather than an individual—responsibility. Which is probably why the Red Cross centers seem to have more trouble keeping up their blood supply than do the A.A.B.B. banks.

A.A.B.B. officials conclude from this fact that there's something inherently wrong with the Red Cross procurement system. Says the A.A.B.B.'s new president, Washington (D.C.) Pathologist Oscar B. Hunter Jr.: "There are practical reasons why you can't have a credit-and-debit exchange system with the Red Cross. It works in a few cities; but in most places, no."

Blood procurement, as Dr. Hunter sees it, "is no longer an amateur's job. This is a day-in day-out business, and volunteers get tired mighty soon. That's why the Red Cross is not a success in most towns. The larger the town, the less successful it is.

"In Washington it is unsuccessful. The blood supply is sporadic, uneven, and at times worse than before World War II. It would seem unheard-of at the present time for a hospital to risk the lives of patients by having only four pints of blood in a bank. But that was the case in one hospital supplied by the Red Cross in Washington during October, 1957."

Dr. Hunter feels that penalty charges are important not only to encourage replacement but also to buy types of blood that are rare or in special demand.

"All successful banks," he says, "purchase Group O Rh-negative blood, because there is a greater use of this blood than exists in the population of hospital patients. If the Red Cross has

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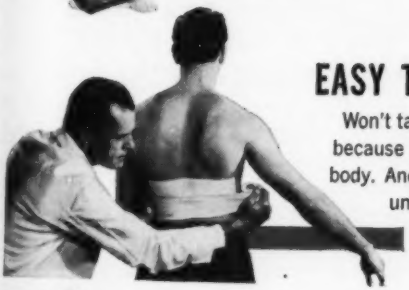

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an adequate supply of Group O Rh-negative blood, they do so only because they waste 15 to 20 per cent of the [other types of] blood drawn. In the past they have been able to pour this into the National Blood Program. What will happen later remains to be seen."

The Red Cross' Dr. Gibson concedes that some of his centers have gone about blood procurement in the wrong way. But he maintains that the benefits of voluntary procurement far outweigh those of the individual-responsibility replacement systems.

"Charge a replacement fee," he says, "and you're not likely to get back more than one or two units of blood. But provide blood for, say, a man who owns a small factory, and you may eventually persuade him to let your bloodmobile visit his plant and collect up to 100 pints."

Dr. Gibson is frankly impatient with banks that keep telling the public how badly blood is needed. The public, he feels, will quickly lose interest in such hat-in-hand appeals.

His theory—and that of the Red Cross in general: Let the public be conditioned to give blood on a regular basis. Suppose the husband of each pregnant woman donated just one unit—4,000,000 units a year! Or suppose you got people to donate blood on their birthdays . . .

Meanwhile, the American Association of Blood Banks continues to prefer its less dramatic—and possibly more realistic—system.

What's Ahead?

Obviously, Red Cross officials don't intend to curtail their blood-banking activities at this time. But they don't appear eager to *expand* Red Cross operations into areas now serviced by other systems. So they give the impression of being fairly well satisfied with things as they are.

The A.A.B.B. is by no means equally satisfied. The Association would like to have a hand in negotiations with the Government for defense contracts. It would also like the Joint Blood Council to become a much more forceful agency than it is today.

The final article in this series will discuss that possibility. It will also explain why many observers believe there's only one way to settle the blood-banking mess: America's M.D.s must step in and arbitrate the issue. END

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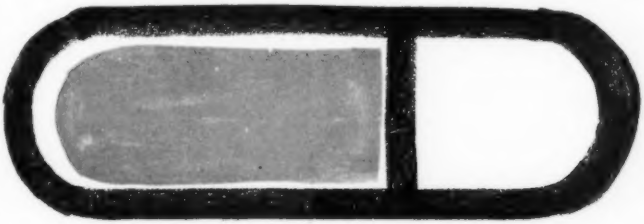

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(1) Barnes, R. H.: A Program of Therapeutic Supports in Obesity, Scientific Exhibit, 106th Ann. Meet., A.M.A., New York, N. Y., June 3-7, 1957. (2) Gelvin, E. P.; McGavack, T. H., and Kenigsberg, S.: Am. J. Digest. Dis. *1*:155, 1956. (3) Natenshon, A. L.: Am. Pract. & Digest Treat. *7*:1456, 1956. (4) Holt, J. O. S., Jr.: Dallas M. J. *42*:197, 1956. (5) Ressler, C.: J.A.M.A. *165*:135 (Sept. 14) 1957.

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The Way to Tell Patients What's Wrong

By John E. Eichenlaub, M.D.

"How long would it take you to make a complete diagnosis?" old Dr. Sampson asked, after reviewing a case with a prospective partner.

"Maybe a week, maybe never," said the young doctor.

"And you wouldn't say anything definite to the patient until your mind was made up?"

"Oh, that's another matter. I'd tell *him* something today."

Dr. Sampson beamed. Here was his man—a young doctor who understood the difference between science and art, between the physician's need for an open mind and the patient's need for reassurance.

It's only natural for the ailing layman to crave some sort of diagnostic statement. The fact that he *is* ailing

worries him—and it may worry him more than you suspect at first. Take Mrs. Pierce, who came to see me a few days ago. Her indigestion had been growing steadily worse. So I suggested a hospital work-up.

"What do you think is wrong, Doctor?" she asked.

"So far, I don't know," I said without thinking. Then, as I saw her eyes grow round with fear, I added quickly: "It's your gall bladder—I'm sure of that. But we'll need some X-rays to show whether it's only inflamed or full of stones."

She gave a deep sigh of relief and murmured: "Then you *don't* think it's cancer."

Apparently, she'd been terrified. The tentative diagnosis was just what she needed.

I've discovered that there are three things the doctor can do to allay the fears of patients like Mrs. Pierce. Here they are:

Make It Black or White

1. Make the preliminary diagnosis as definite as possible, even if it has to be modified later.

"Patients like an absolutely flat statement about their disease, with no hedging qualifications. And that's what I always try to give them," says one top-notch internist.

"But what if you don't know what's wrong?" I once asked him.

"Even so, I make it *sound* definite," he replied. "I've told patients they have 'stomach trouble' or 'virus infection' lots of times. Such terms are too inclusive to mean anything. But they generally satisfy the patient until I can narrow the diagnostic field."

"Is that your major objective—to satisfy them?"

Allay Their Fears

"No, I want mainly to *reassure* them. Give the patient a known entity, even a scientifically meaningless one, and he's likely to put aside all his vague—and even unhealthy—fears. The unknown is what terrifies most people."

Definiteness helps in other ways, too. My partner points out that a direct diagnostic statement often makes patients cooperate better:

"Suppose you tell a patient, 'Look, I've no idea what's wrong with you or what's going to happen next, but you'd better go to bed, quit smoking, and leave the salt off your food.' He probably

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Effects of anticholinergic drugs on peptic ulcer[1]

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Daily Dose	1.6 mg.	400 mg.	120 mg.	200 mg.
No. patients and length of follow-up	37 11 mo.	27 13 mo.	16 9 mo.	21 11 mo.
Results:				
Good to excellent	51%	74%	56%	76%
Fair to poor	49%	26%	44%	24%
Recurrences:				
None	16%	22%	13%	19%
Few	46%	48%	50%	57%
Same	38%	38%	38%	24%
Complications:				
Hemorrhage	5%	7%	19%	9.5%
Perforation	0%	4%	0%	0%
Obstruction	0%	4%	0%	0%
Surgery needed	3%	4%	6%	0%
Side effects:				
Oral	38%	78%	25%	14%
Visual	11%	48%	6%	0%
Sphincter	11%	15%	0%	0%

Available in three forms: tablets of 25 mg., plain (Pink) or with phenobarbital, 15 mg. (*Blue*), and parenteral, 10 mg./cc.—1 cc. ampuls.

Dosage: 1 or 2 tablets before each meal and at bedtime. Parenterally, 10 to 20 mg. every 6 hours.

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1. After Cayer, D.: Prolonged anticholinergic therapy of duodenal ulcer, Am. J. Digest. Dis. *1*:501 (July) 1956.

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won't do as you suggest, since he sees no reason for it.

"But suppose you say: 'You've got trouble with circulation. We'll need more tests to pin it down further. Meanwhile, off to bed with you—and no tobacco or salt.' He's likely to take *that* sort of statement seriously."

No doctor wants to make wild guesses or to sound all-knowing. But if you keep your tentative diagnoses reasonable and general enough, you needn't hang back for fear you might have to eat your words later on. Says an internist with forty years of successful practice behind him:

"Sure, sometimes your original idea proves wrong. I've back-tracked a thousand times. I don't believe it's ever undermined a patient's confidence in me, though. You tell a man something fairly definite, and then new developments or lab tests prove you've made a mistake. If you explain *why* you've changed your views, the patient generally goes along with you."

2. *Make the prognosis equally definite, with the time element clearly stated.*

Most of the diagnostic labels you're likely to use will convey some idea of the path ahead. But why stop there? If it's at all possible, why not tack on a specific prognostic phrase?

One of our local G.P.s calls pleurodynia "sore lung lining." And he usually adds: "It's the

"What makes you say World War II was all your fault, Mrs. Schnur?"

a new look at BANANAS

Some years ago there was a widely prevailing notion that bananas were indigestible. Today they are prescribed as one of the first solid foods fed to infants.

For the past few years many patients have had the idea, equally erroneous, that bananas are "fattening." The fact, of course, is that bananas—like fruits as a class—are relatively low in calories. There are only 88 calories in a medium banana, according to the U.S. Department of Agriculture. (Handbook No. 8, Composition of Foods.)

And so another bugaboo is laid to rest.

There is no reason to omit bananas from reducing diets. There are a wealth of reasons to include them:

- *A wide range of vitamins and minerals in good balance with calories.*
- *Calories provided both as simple sugars for quick energy and as less soluble carbohydrates for sustained vitality.*
- *High satiety value for appetite control.*
- *Pectins and carbohydrates to aid digestion.*
- *Extremely low fat content—less than 0.2 per cent.*
- *Sweet mellow flavor that rates high in patient acceptance.*

In addition, clinical experience has demonstrated the banana's regulatory effect on gastrointestinal function, and its value in the correction of both diarrhea and constipation.

A new look at bananas demonstrates their place in every reducing diet—and every normal or maintenance diet, too.

Bananas belong in the daily diet

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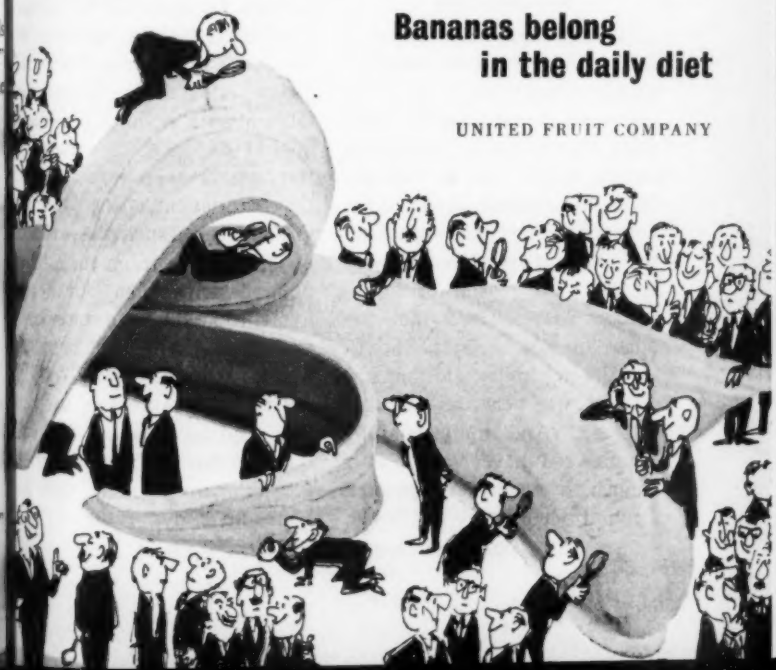

kind that gets well after a few days' rest." I once heard him tell a patient with a Nabothian cyst that she had "a stopped-up gland at the mouth of the womb —the kind that never turns into a cancer and gets well with a touch of heat."

I think that's a sound technique. If the prognosis is good, seems to me, the patient ought to be told so right off, without having to ask. And the wise doctor puts the information in direct terms that are sure to be understood.

Reassure Him

3. *Anticipate the patient's doubts and fears about other ailments he may think he has.*

Every doctor knows how some laymen make far-fetched mental leaps. One of my patients, for instance, divorced her husband many years ago after she'd had an operation for ovarian cyst. The reason for the divorce: She believed that *her* operation was *his* fault.

"The neighbors said that sort of thing was venereal," she has told me. "And in my youthful ignorance I never gave Bill a chance to explain. Years later, I found out that my cyst was a growth. But I've never seen Bill again."

One doctor who has made a study of iatrogenicity in illness says patients often act on misapprehensions about the following factors in illness: venereal disease, infertility, communicability, possible disability, the need to change localities, and the need to shift jobs. You can spare them lots of misery by anticipating such misapprehensions and setting them straight.

A gynecologist whom I know makes a definite statement on V.D. and fertility in every case he sees. He makes it no matter how far-fetched the inference or how prim the patient. To avoid giving offense, he sometimes talks about "nothing catching" instead of "nothing venereal." But he never takes it for granted that the patient is too well informed to need such reassurance.

There's no room for fixed opinions in medicine. But there's lots of room for fixed statements to patients. "What's the best way to treat a diseased body?" one of my Hopkins professors used to ask. And he'd answer his own question this way: "First of all, calm down the mind that inhabits the body." END

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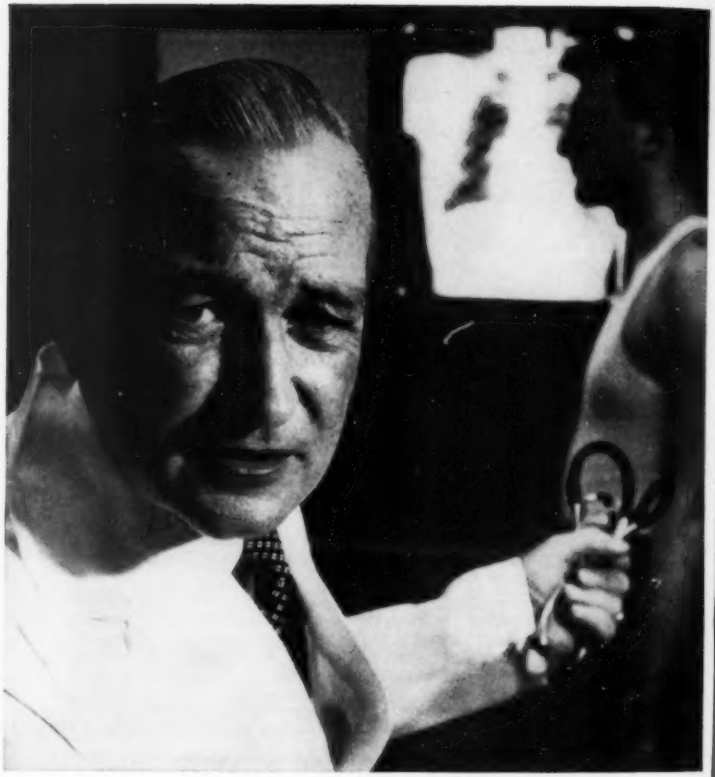

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LAKESIDE

Protect Yourself From Addicts' Dodges!

It's now harder for addicts to buy drugs illegally. So you'll have to be on your guard more than ever

By Clifford F. Taylor

The drug addict's search for narcotics is becoming increasingly desperate. Reason: By stiffening the penalties for illegal sale of narcotics, the Federal Narcotics Control Act of 1956 has frightened many dope peddlers out of business. So the addict must seek other sources of supply.

What other sources? Doctors, naturally. To get drugs, the addict may play on your sympathy, your carelessness —or both. Desperation makes him ingenious. And if his ingenuity works, it can mean trouble for *you*.

As the Bureau of Narcotics often points out, it's a good idea for every doctor to make a periodic check of his narcotic precautions. This time, try doing it in the light of these five dodges that addicts are using today:

Dodge #1: They're visiting doctors' offices for the sole

purpose of stealing Rx blanks.

To the man who isn't above forgery, an Rx blank is as good as a filled-out prescription. And his current success with this dodge suggests that many doctors are careless with prescription pads.

Light-Fingered Addict

One Los Angeles doctor thought his pad was perfectly safe if kept within reach on the top of his desk. Not so—not with an unsuspected addict in the office. It wasn't until the police confronted him with the addict that the physician was able to place the man as a stranger for whom he'd written a nose-drop prescription a month before. Then he recalled that on the same afternoon he'd apparently "mislaid" his Rx pad.

About forty morphine prescriptions bearing his forged signature had thereafter been filled for the patient. Fortunately, one druggist familiar with the doctor's signature got suspicious and called the police. When apprehended, the addict still had a number of unused blanks bearing the doctor's name and number.

Another addict has told Chicago narcotics agents it's relatively easy to get Rx blanks. He claims that prescription pads can be found on the receptionist's desk in about one out of ten medical offices. Why on the receptionist's desk? For use as a scratch pad!

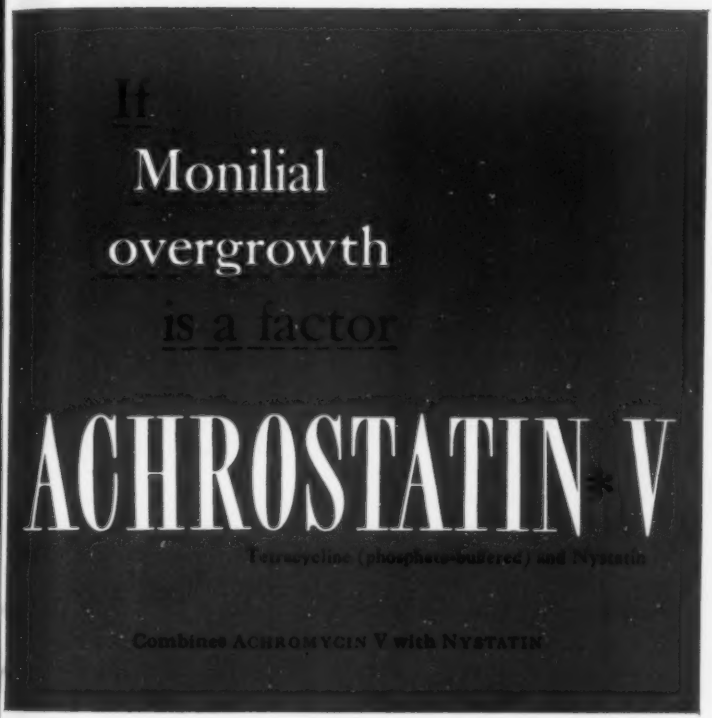
The cautious doctor takes no such chance. He keeps prescription blanks in a desk drawer. The pad goes back into the drawer immediately after he's through with it.

Phony Pains

Dodge #2: They're simulating symptoms that suggest the need for narcotics—in some cases, with fanatical zeal.

Many addicts spout thoroughly credible histories of such ailments as migraine and kidney colic. These days, though, they're going further. They're finding ways to produce bloody sputum or bloody urine. They can affect realistically bad coughs. And sometimes their persistence carries them still further:

One addict sliced the blood vessels below his tongue before entering an Ohio doctor's office. The doctor checked the bleeding but refused the man's request for pain-killing drugs. So as soon as



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he'd left the office, the patient threw himself in front of a slow-moving car. And on the way to the hospital, he tried to steal narcotics from the ambulance that was taking him there.

It takes a thorough examination to expose self-inflicted symptoms. That's why the wise doctor insists on a careful going-over with every stranger whose complaint seems to call for narcotics.

Tall Tales

Dodge #3: They're telling ingenious stories in an effort to get the doctor to prescribe narcotics for somebody else.

A Wisconsin physician fell for one such story not long ago. A stranger reported he had a seriously ill wife. Her nurse, said the man, was driving her out from the East Coast. Would the doctor look after her when she arrived? Naturally, the doctor agreed to care for the ailing woman.

The next day, the man was back. His wife had become too ill to continue the trip, he explained. She and the nurse had stopped at a small town along the way. But she'd been given only enough morphine to last the trip. Would the doctor make out an emergency prescription he could send the nurse?

The doctor swallowed the story. A few minutes later, the man left the office with the Rx in his pocket. It wasn't until weeks later the physician learned that three of his local colleagues had been equally trusting.

You'd never be that gullible? Maybe not. But a desperate addict is a persuasive talker. For proof, consider the Midwestern doctor whose case has become a classic in the annals of the Narcotics Bureau:

A man and a woman showed up at his office. The woman, young and attractive, introduced herself as a nurse and her elderly companion as her father. Both were from out of town. She produced a note from their family doctor. The old man, it said, had inoperable cancer and needed periodic doses of morphine.

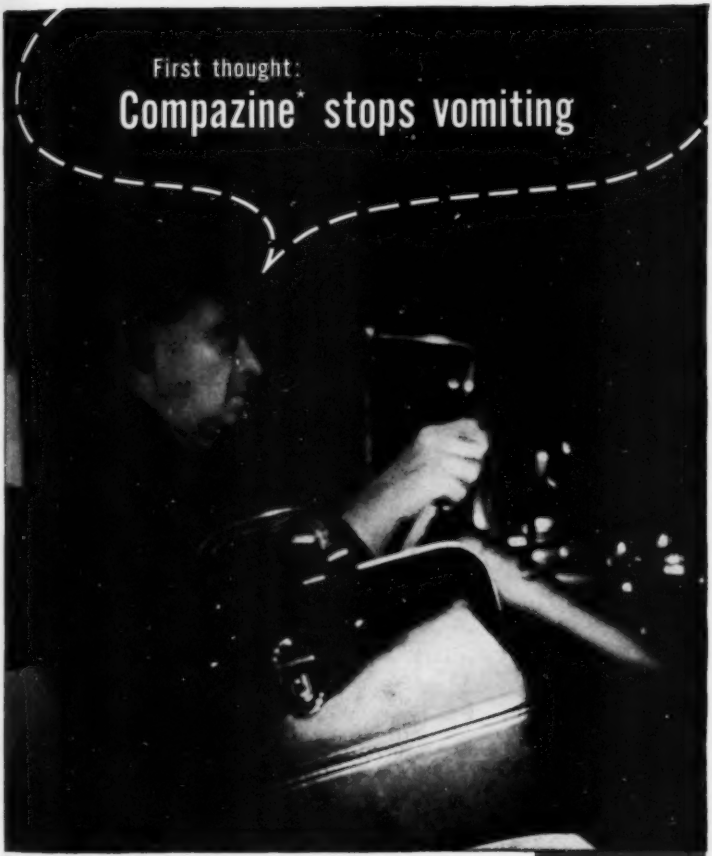
He Believed It

The set-up was so believable that the doctor wrote out a prescription without examining the patient. A week later, the woman came back to say that "Dad" needed more morphine. Once more, the doctor obliged.

Believe it or not, this little

First thought:

Compazine* stops vomiting



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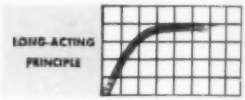

patients with colds... sinusitis ... rhinitis will appreciate the "Novahistine LP Effect"

When a patient begins breathing freely in a few minutes ... with all air passages cleared ... and this relief continues for as long as 12 hours after a single dose ... he is experiencing the "Novahistine LP Effect."

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Phenylephrine hydrochloride ..... 20 mg.
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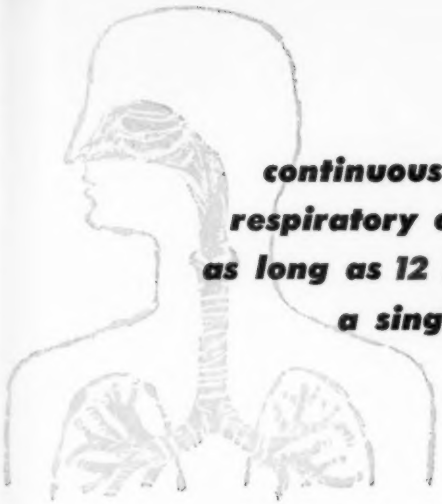
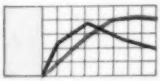
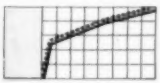


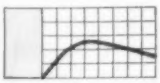
continuous relief of respiratory congestion for as long as 12 hours with a single dose



PROMPT RELIEF
Novahistine LP Tablets start releasing medication almost as rapidly as a solution.



CONTINUOUS RELEASE
Novahistine LP releases its decongestive drugs at a constant rate in both acid and alkaline media . . . assuring patients continuous relief whether the tablet is in the stomach or intestine.



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Found "—*effective in 82%*—"* of the patients observed, all of whom had tenderness and pain and some muscle spasm.

For relief of low back pain, muscular rheumatism, shoulder girdle pain, torticollis, and generalized myositis.

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Potentiated Mephenesin*

- *Relieves Pain*
- *Soothes Tension*
- *Relaxes Muscle Spasm*

*Skeletal muscle relaxing mephenesin physiologically potensified with an analgesic—salicylamide, and a smooth muscle relaxant—dibenzyl succinate.

*Tebrock, H. E., et al, N. Y. State J. Med. 57; 101; 1957.

Each *EXPASMUS* tablet contains:
Dibenzyl succinate 125 mg.,
mephenesin 250 mg., salicylamide 100 mg.

DOSAGE:
2 to 3 tabs. 3 times daily to 12 tabs. daily.

SUPPLIED: Bottles of 100's.

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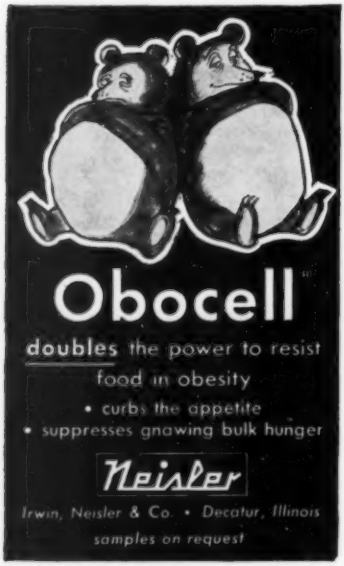


drama was re-enacted until the doctor had prescribed 3,130 half-grain morphine sulphate tablets. He might be doing it yet if narcotics agents hadn't stepped in. The woman and "Dad" were both addicts.

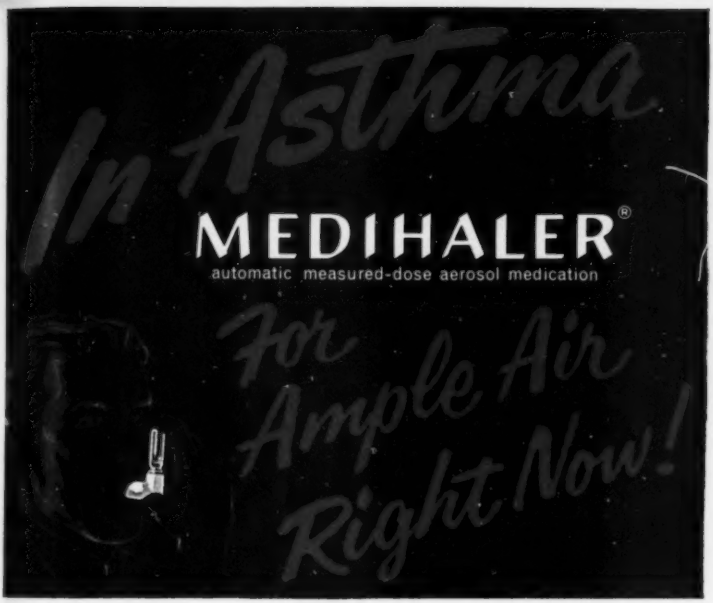
Pleas for Help

Dodge #4: They're confessing their addiction and asking the doctor to help them break the habit.

Knowing that the drug addict is a sick person, you naturally want to help him. But as any number of physicians have learned to their regret, it's dangerous if done informally.

Take the experience of a certain Baltimore doctor. He agreed to help an addict "just this once" on the man's promise to seek immediate hospital care. Then, for almost three months, the addict found one reason after another for delay. Meanwhile, the trusting practitioner gave him the morphine he craved. That doctor had a hard time explaining his patience to the narcotics agent who investigated after a routine check of druggists' files.

The law specifies that you should prescribe narcotics "in the course of your professional practice only." And the Bureau of Narcotics maintains that treat-



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Riker LOS ANGELES

ment of drug addiction does *not* belong in the private physician's practice. To back up its stand that the addict must be institutionalized, the Bureau can cite innumerable cases of addicts who've received simultaneous "treatment" from several M.D.s.

Altered Rxs

Dodge #5: They're capitalizing in numerous other ways on carelessly written or telephoned prescriptions.

Suppose, for example, you write : "Morphine HT ½ # X." Or: "Morphine ¼ # 10." It's easy to add additional Xs or zeros to prescriptions of this sort. That's why many physicians enclose the prescribed amount in tight brackets, or even spell out the number. And they do it as a matter of routine, no matter how well they know the patient.

What's more, they never order narcotics prescriptions by phone. It's illegal for a druggist to fill such a prescription. But an occasional druggist *will* do it to oblige the doctor. The clever addict is adept at capitalizing on such laxity.

Identifying himself as Dr. So-and-So, he phones the obliging pharmacist, orders a narcotic compound sent to a certain address, and promises to drop the prescription off the next day. But by the next day the damage has been done.

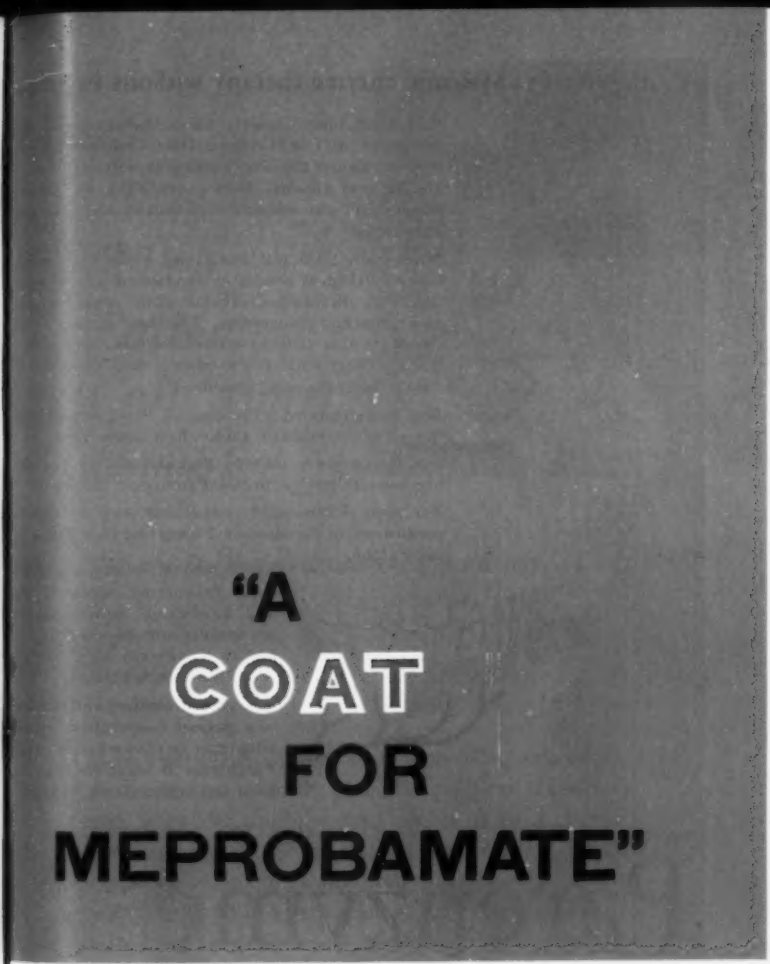
The Narcotics Bureau points out that this trick is worked successfully again and again. But it can't succeed if the druggist knows that the doctor in question *wouldn't* phone in a request for narcotics. END

Dry Run

A stranger phoned me excitedly to come at once—his wife was in agony and, being new to the city, he had no family doctor.

So I rushed to his house. He was waiting on the porch, beaming. "That was a quick trip, Doc!" he said. "My wife isn't really sick, but come on in and meet her. The real reason I called was to see who I could depend on if we ever *did* have an emergency."

—V. E. QUANSTROM, M.D.



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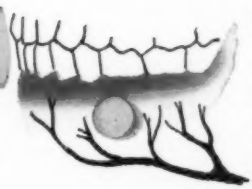
The recommended daily dose of Parenzyme **B** is 20 mg.—one 5 mg. buccal tablet, four times daily.

For maintenance therapy Parenzyme buccal tablets are used following initial Parenzyme injections.

For mild inflammatory conditions such as sprains, contusions, or hematomas, Parenzyme buccal may be used alone.



For severe inflammatory conditions Parenzyme buccal tablets and Parenzyme Aqueous (I.M.) are usually administered concurrently to sustain high trypsin levels between injections.

The greater comfort and freedom win patient cooperation, ensure adherence to your schedule, make Parenzyme B ideal for ambulatory and maintenance therapy.

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PARENZYME IN OIL
(25 mg. trypsin in 5 ml. vial)

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When Patients Call Your Home

Here are five tips on phone technique to pass on to your wife and kids and your maid, if any

By Joan Morse

Does your practice totter when your office aide displays a brusque manner on the phone? A couple of recent MEDICAL ECONOMICS articles have implied as much. But as a doctor's wife, I'd like to suggest that your *home* aide's telephone technique is also pretty important.

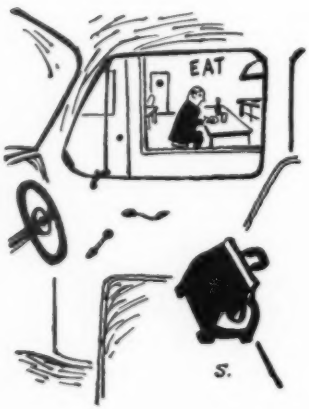
My husband is a pediatrician. We have four children ranging in age from 1 to 7. And we have one telephone with a cord ranging twenty-four feet. This is a very fine set-up for me. All it demands is superhuman finesse.

So I feel well equipped to give advice to others. When you pass the following phone tips along to your wife, Doctor, you can tell her they're from a woman who's had plenty of experience—mostly painful:

1. Whenever the doctor's wife is too much entangled in household chores to answer the telephone sweetly, she'll be smart not to answer at all. For instance, suppose she races up—or down—two flights to the phone, carrying laundry and/or a crying infant in her wet hands. After she pants her greeting, some feminine voice may coo: "Oh, it isn't important. I just thought of something to ask the doctor."

What Can She Say?

Any retort the wife is likely to make can alienate a patient. So tell the good woman to let the phone ring—and put her trust in the answering service.



2. Tell your wife to fight down any temptation to treat patients over the phone. I've sometimes succumbed to an irresistible urge to do so. (After all, I need *some* ego-strengthening after drab years of changing diapers and rewarming delayed meals.) And what have I got for it? Hell, that's what I've got.

Says my husband: "Sure, you know all the answers, Darling. But kindly keep them to yourself. Who wears the M.D. in this family? *I* do."

3. When patients describe their problems via the telephone, your wife will do well *not* to take them lightly. An anxious mother once treated me to ten minutes of soul-searching on whether she should take the baby outdoors on a cold day.

Finally I quipped:

"You don't worry about such matters when you have four."

(My husband *didn't* quip when he heard about it—from her, of course.)

Mystery Man

4. When the doctor is disinclined to come to the phone except for emergencies, it's up to his wife to start the smoke screen. It's bad business to re-

for more blood flow

a potent peripheral vasodilator

oral Priscoline®

hydrochloride
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Orally and parenterally effective, intra-arterially as well as intramuscularly and intravenously.
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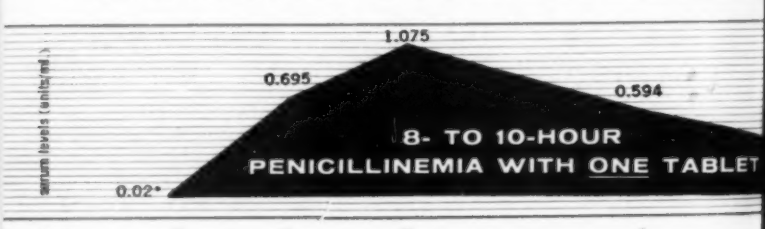

*Bactericidal concentration for Group A beta-hemolytic streptococci-experimental infections in mice (Eagle, H., and others: Am. J. Med. 9:280 [Sept.] 1950).

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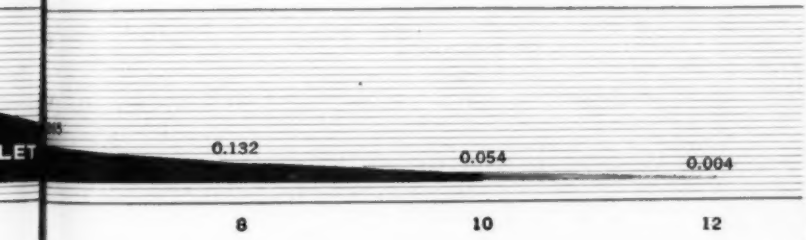

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Clinical investigators report that in clinical studies*

Postoperatively	After Nitrogen Mustard Therapy	In Chronic Nausea and Vomiting	In Infections, Intra-abdominal Disease, and Carcinomatosis	In Neurosurgical Diagnostic Procedures	In Pernicious Vomiting of Pregnancy

VESPRIN

- showed potent antiemetic action
- completely relieved nausea and vomiting in small intravenous doses
- showed a prolonged antiemetic effect
- caused little or no pain at injection site
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*Reports to the Squibb Institute for Medical Research

antiemetic dosage: *Intravenous route*—2 to 10 mg. for therapy or prophylaxis
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Oral route—Prophylactic doses may range from 20 to 30 mg. daily

supply: *Parenteral Solution*—1 cc. ampuls (20 mg./cc.)
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"VESPRIN" IS A SQUIBB TRADEMARK

lease exact information about his current activities.

Perhaps you think patients would be reassured to know that the doctor's taking a shower or bucking himself up with an uninterrupted dinner. You're wrong. I've seldom spoken to a caller who would concede my husband's right to minister to his own needs as well as to the patient's.

The Magic Words

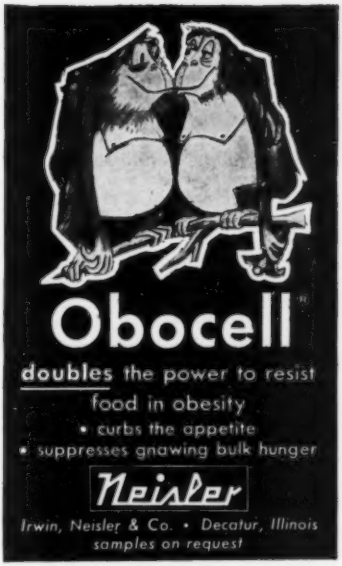
By now I've learned when it's wise simply to indicate that my husband is busy but will gladly call back soon. This lets the caller assume that a life is being saved. Why specify that the life may be the doctor's?

5. If your children often win the dash at the sound of the bell, it's a good idea to teach *them* evasive techniques. Small fry, for example, can be coached not to shout beside an open telephone line: "Daddy, which are you—in or out?"

How They Don't Lie

Naturally, I haven't trained mine to lie. I've taught them to say something like: "Well, my mother's here. I'll let you talk to her."

That way, I have *some* stature, at least. END



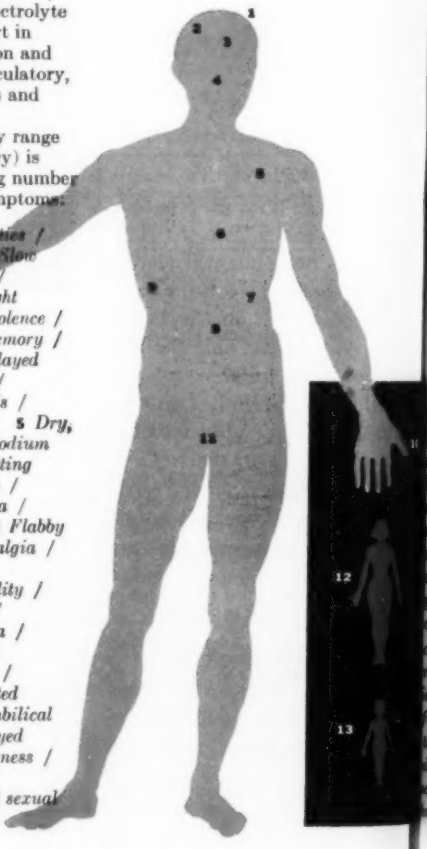
HYPOTHYROIDISM

a single syndrome with a host of sympto

Thyroid secretion acts on every system, organ, tissue and cell of the body. It controls the general metabolism; promotes growth and development; affects protein, carbohydrate and fat metabolism; helps regulate water and electrolyte balance; takes an active part in maintaining normal condition and function of the skin and circulatory, digestive, muscular, nervous and reproductive systems.

Hypothyroidism (which may range from slight to total deficiency) is manifested by an astounding number and variety of signs and symptoms:

1 *Low BMR / Cold extremities / Elevated serum cholesterol / Slow pulse rate / Lack of energy / Sensitivity to cold / Overweight* **2** *Dry, falling hair* **3** *Somnolence / Chronic fatigue / Failing memory / Inability to concentrate / Delayed reflexes / Chronic headache / Irritability / Frank psychosis / Paresthesia* **4** *Chronic colds* **5** *Dry, coarse skin* **6** *Anemia* **7** *Sodium and water retention / Nonpitting edema / Diminished diuresis / Albuminuria* **8** *Achlorhydria / Flatulence / Constipation* **9** *Flabby muscles / Backache / Arthralgia / Myalgia* **10** *Brittle nails* **11** *Decreased libido / Infertility / Impotence* **12** *Amenorrhea / Dysmenorrhea / Menorrhagia / Functional uterine bleeding / Habitual abortion / Sterility / Failure of lactation* **13** *Stunted growth / Macroglossia / Umbilical hernia / Yellow skin / Delayed dentition / Apathy / Hoarseness / Delayed skeletal maturation / Mental retardation / Delayed sexual development / Cretinism*



DEFINITION: SUBCLINICAL HYPOTHYROIDISM (METABOLIC INSUFFICIENCY)—Recently a new name—"metabolic insufficiency"—has been applied to cover such symptoms as fatigue, lassitude, decreased mental alertness, dry skin and hair, brittle nails, inability to lose weight and high cholesterol blood levels. These are the familiar symptoms of subclinical hypothyroidism.

DIAGNOSIS—In the past, BMR has been relied upon as the most accurate measure of thyroid activity. More recently, the determination of PBI, as well as I^{131} uptake, has been used successfully by many clinicians. Another new contribution in the field of diagnosis has been the development of triiodothyronine. Thanks to its rapid action (BMR may increase from −41 to +4 within 24 hours) triiodothyronine affords a fast therapeutic test for hypothyroid function. On the other hand, for therapy, thyroid is preferred by most clinicians because of its gradual cumulative action.

PROLOID® WHENEVER THYROID IS INDICATED—Since hypothyroidism is often a lifetime deficiency, many patients must take thyroid for the rest of their lives. Long-term treatment necessitates a simple, safe, economical therapy. Proloid (purified thyroglobulin) provides the total thyroid complex. It contains all fractions of thyroid secretion in their natural physiologic ratio. Proloid provides economical and *complete* substitution therapy. It affects all the parameters of thyroid function and its effect is gradually cumulative rather than precipitous. It is also free of side effects. Because Proloid is *doubly* assayed, biologically (in test animals) as well as chemically, the clinician is assured of a smooth predictable clinical response.

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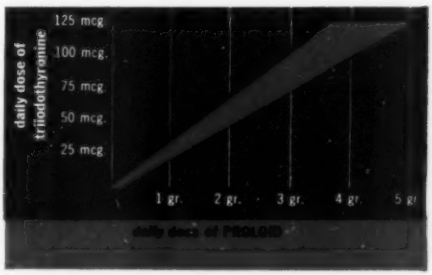

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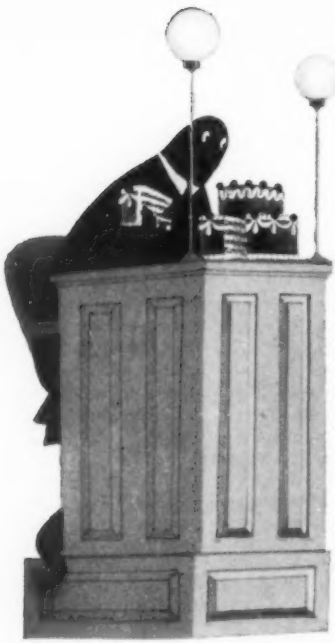

When

Temptation

puts him

on trial . . .

802074

[CONTINUED FROM 98] especially important. "In the absence of a large middle- and upper-class population," says Dr. Frederick C. Thorne, editor of the Journal of Clinical Psychology, "a psychiatrist must usually supplement his income by acting as consultant for welfare and governmental agencies. In addition, religion may be an important factor. In a predominantly Catholic area, for instance, a non-Catholic psychiatrist will get only about half the referrals a Catholic psychiatrist would. Much also depends on how well the population has been educated to request psychiatric treatment when it's indicated. Where there has been little education, it will take twice the population it otherwise would take to support one psychiatrist."

Regional Differences

Radiology: 12,000-35,000. Dr. Barton R. Young, secretary of the American Roentgen Ray Society, makes a distinction here between the South and the rest of the country. His estimates: 20,000 in the South, 12,000-15,000 everywhere else. But Dr. Earl E. Barth, chairman of the Board of Chancellors of the American College of Radiology, believes that "a physician limiting his

practice to radiology needs a minimum population of 20,000 to 30,000 from which to draw referrals. Lower estimates must be based on circumstances not normally present." With a national population of about 170,000,000 and a radiologist population of 5,500, Dr. Barth points out, the national ratio is currently 31,000 people per radiologist. And he adds: "Special considerations for the radiologist to take into account include the size of the hospital in the community; also the tendency of local physicians to refer certain work (i.e., orthopedic cases) outside the community."

Anesthesia 'Vital'

Thoracic Surgery: 100,000. Adds Dr. William Tuttle, secretary of the American Board of Thoracic Surgery: "The most vital facility for the thoracic surgeon . . . is good anesthesia."

Urology: 15,000-20,000. Says Dr. William N. Wishard Jr., secretary-treasurer of the American Board of Urology: "We've certified full-time urologists in towns with a population as small as 5,000 and with a surrounding population of 10,000 or 15,000. But I think it usually takes at least 20,000 to support one full-time man." END

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* Livingood, C.S.; Fosnaugh, R.P.,
MOD. MED. 25:71, June 1, 1957

DOME *Chemicals Inc.*
109 WEST 64 ST., NEW YORK 23, N.Y.
In Canada: 2765 Bates Rd., Montreal, P.Q.

HOUSE CALLS

[CONTINUED FROM 152] little boys, the husband's mistress, and the mistress' four little girls. The wife had just found out about the mistress. Why had *I* been called in? Because, it appeared, I was looked on as an intimate family friend. I prescribed sedatives all round, gave some advice, and was able to leave by midnight."

The topper is told by an Ohio city man who was called to the country by strangers for an OB case. "It was 15 below," he says. "I drove until I got stuck in a snowdrift. Then I got out and floundered on for about an hour in a foot and a half of snow. Then the husband met me with a horse—no saddle. I rode bare back for another hour.

"It was so cold I couldn't grip with my knees. So I'd slide to the horse's rump when he went uphill; and I'd find myself riding his neck when he went downhill. At the farmhouse, I took off my icy shoes and socks and delivered the baby in my bare feet. Then was there forty-five minutes. The round trip took me over seven hours and wore a hole in the seat of my pants. And I've never heard from the people again!"

How far do doctors go on house calls? Apparent answer: to great lengths.

"Most patients were completely relaxed without having a 'drugged', 'sedated' feeling . . . . Apparently, the less frequent dosage enabled the patient to forget his illness for a longer period of time, and this contributed appreciably to the general feeling of relaxation."

* * *

"The incidence of side effects . . . was non-existent with the sustained release medication ['Eskaserp']."

Christman, R.S.: Am. Pract. & Digest Treat. 7:614.

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the preferred drug *in the preferred form*

a single oral dose . . .
—provides gentle, long-lasting relaxation
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. . . around the clock . . . with minimal side effects

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patients "...the most satisfactory drug ...in the suppression of lactation."[1]

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1. Eichner, E., Goler, G. G., Sharzer, S., and Horowitz, B.: Obst. & Gynec. 6:511, 1955. 2. Greenblatt, R. B., and Brown, N. H.: Am. J. Obst. & Gynec. 63:1361, 1952.

TRADEMARK, reg'd

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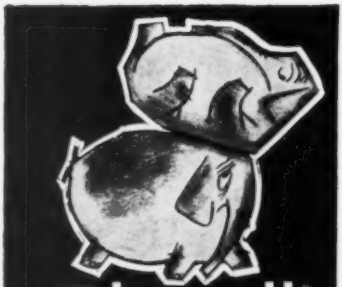

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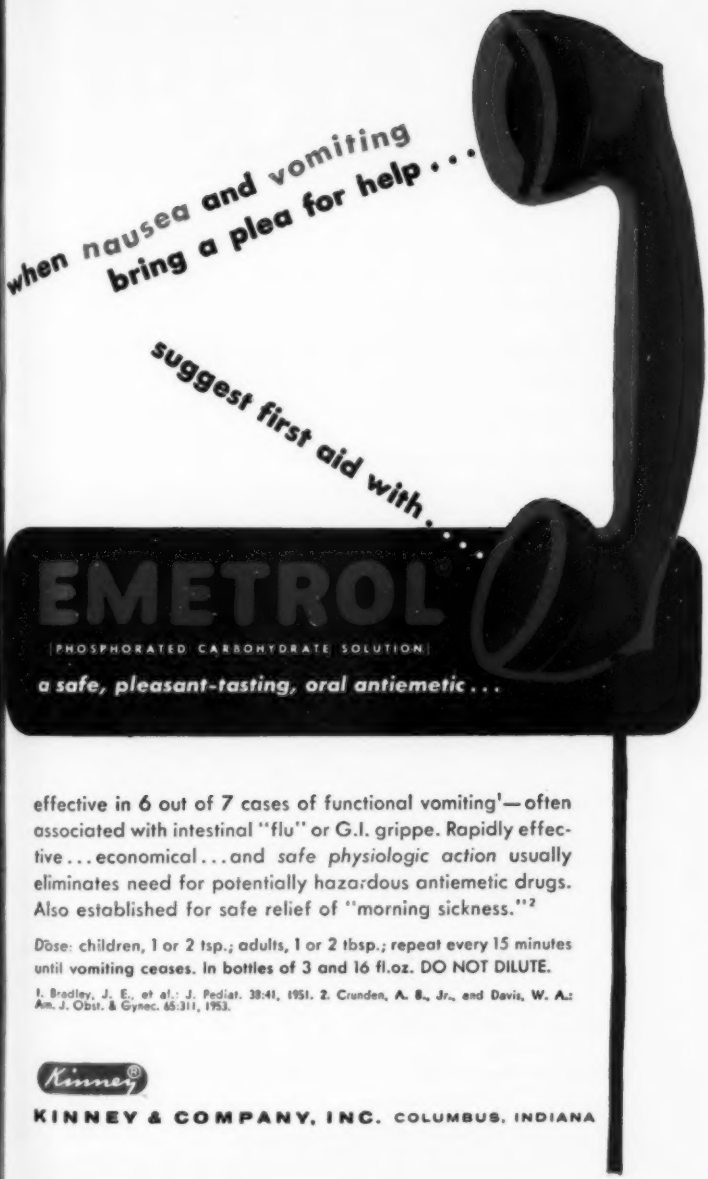

effective in 6 out of 7 cases of functional vomiting[1]—often associated with intestinal "flu" or G.I. grippe. Rapidly effective . . . economical . . . and *safe physiologic action* usually eliminates need for potentially hazardous antiemetic drugs. Also established for safe relief of "morning sickness."[2]

Dose: children, 1 or 2 tsp.; adults, 1 or 2 tbsp.; repeat every 15 minutes until vomiting ceases. In bottles of 3 and 16 fl.oz. DO NOT DILUTE.

1. Bradley, J. E., et al.: J. Pediat. 38:41, 1951. 2. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311, 1953.

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Memo

FROM THE EDITORS

Coming in March Every other Monday brings you a new issue of MEDICAL ECONOMICS. That makes March a bonus month bringing you *three* new issues. Look for them on Mar. 3, Mar. 17, and Mar. 31. And look especially for the following articles that we think you won't want to miss:

Loopholes in Your Malpractice Coverage

Even the best insurance available doesn't protect you against all professional liability risks. You need to know where you're vulnerable. This translation of common contract clauses will help

When Doctors Bargain With the Government

Your fees for Medicare patients are being negotiated in Washington at bargaining sessions like this one. Here's what it's really like for private physicians to do business directly with Uncle Sam

Grievance Committee With Teeth

In doctor-patient disputes, this committee's determination of a fair fee is binding on medical society members. They can be expelled if they don't accept it. Here's their experience to date

What the Experts Say About Social Security

Insurance industry spokesmen point out: 'M.D.s already have large amounts of Social Security coverage' . . . 'It's a bargain today, but what about tomorrow?' . . . 'The cons just about balance the pros'

Tax Savings You're Likely to Overlook

They're small items, some of them—but under the right circumstances they can add up to big deductions. The list ranges from taxi fares to tax services, from real estate to Christmas gifts

What Fringe Benefits for Doctors' Aides?

Here's prevailing policy on paid holidays, bonuses, raises, overtime pay, and the like, as shown by a MEDICAL ECONOMICS survey